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CIS

LONG-TERM HEALTH CARE FOR THE ELDERLY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

NEWARK, N.J.

JULY 26, 1982

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1982

99-345 O

5141-21

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LONG-TERM HEALTH CARE FOR THE ELDERLY

MONDAY, JULY 26, 1982

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Newark, N.J.

The committee met, pursuant to notice, at 2:15 p.m., in room 232, Paul Robeson Center, Rutgers University, Newark, N.J., Hon. Bill Bradley, presiding.

Present: Senator Bradley.

Also present: David Rabin, legislative assistant to Senator Bradley; Ann Langley, professional staff member; and Kathleen M. Deignan, minority professional staff member.

OPENING STATEMENT BY SENATOR BILL BRADLEY, PRESIDING

Senator **BRADLEY**. The committee will come to order.

This is an official hearing of the Special Committee on Aging. A transcript of this hearing will be published. In addition to the scheduled witnesses, we hope to have enough time at the end to take short additional testimony on the subject from members of the audience. If there is not enough time for everyone to be heard, the committee will take written comments. They will be a part of the record, and there are special forms in the back of the room that may be used by those who would like to submit written comments. If you don't have a chance to make the statement during the course of the hearing, you can mail those to my office, or you can hand them in today.

Last week, I was engaged in Senate debate over medicaid and medicare expenditures for the next 3 years. As you know, Federal medicaid expenditures were capped last year and will be for the next 2 years. Additional medicaid cuts were adopted by the Senate this year.

Fifty percent of medicaid expenditures go for long-term care. Since most States have not been able to pick up the increased costs for medicaid, these reductions will have substantial impact on the long-term care system.

This year, medicare took the brunt of the funding cuts. The Senate-passed bill increases the elderly's out-of-pocket expenses and shifts even more of the cost of hospital and medical care to private insurers.

The elderly will have less to pay for long-term care services, and hospital funding limits will encourage earlier patient discharge, placing more demands on the long-term care system.

Title XX of the Social Security Act, the third major source of funding for long-term care, suffered a loss of $500 million in Federal aid and has been bloc granted. The Older Americans Act social services programs have also suffered some funding cuts.

This happens to be the budgetary circumstance that surrounds health care as it pertains to the elderly and long-term care. It is not encouraging. The erosion in Federal aid must also be seen in the context of the rapidly increasing aged population.

During the 1970's, the number of people 65 years or older increased by 5 million nationally. By the year 2000, that figure will increase 30 percent, or by 7 million people, making a total of 32 million Americans over age 65.

Of far greater significance is the old, old American, those Americans over 85 years of age. Between 1960 and 1980, this age group doubled in number to 2.4 million individuals, and it is projected to increase over 150 percent in the next 20 years.

Since 20 percent of those individuals age 85 or older are in nursing homes, the demand for long-term care is sure to increase markedly. High interest rates have inhibited the building of new nursing homes; medicaid and medicare cutbacks make the future level of nursing home reimbursement uncertain. As a result, few nursing homes are being built.

I have sponsored two bills to better coordinate long-term care and provide alternatives to institutional care. They would assure that funds are spent in the most efficient way and that care is provided in the most appropriate setting.

One is bill S. 861, that I introduced with Senator Packwood in the Senate, to establish statewide demonstrations of coordinated community home care under title XXI, a new title, of the Social Security Act.

Home care services financed by medicare, medicaid, and title XX would be consolidated, and a broader range of home care services would be available.

A second bill that I introduced, S. 1958, would provide expanded hospice care, primarily in the home, for the terminally ill. A modified version of that bill was attached to the tax legislation last Thursday evening.

While I recognize that hospitalization or nursing homes may be necessary for some patients, I believe that many others could and should avoid being forced to go to an institutional setting. Both of these bills are meant to help people receive the right mix of social and medical services they need to remain in their own homes and in their own community.

We have some nationally significant examples of a coordinated approach to keep people in their homes right here in New Jersey. We have dedicated professionals who are working to meet the increased long-term care demands, even in a time of diminishing health resources. We will hear today of the early experiences of the New Jersey channeling demonstration project, 1 of only 10 in the country. This program, in Middlesex County, and another one in Union County, without special support, are examples of the pooling of Federal and State funds and the coordination of local services along the lines I have proposed in my title XXI legislation. From the testimony today, I hope to learn ways that we can make any eventual long-term health care legislation, even based upon New Jersey's experience.

We will also hear from Burlington County Memorial Hospital, which has responded creatively to the reality of decreased funding, and more demand for long-term care. The hospital's move into long-term care services shows us how hospitals all over the Nation may respond to a reimbursement system like the prospective system New Jersey is currently demonstrating.

Our last speaker will be from Massachusetts. He will describe a 6-year evolution of a statewide coordinated community long-term care system in that State.

By the day's end, we should glimpse some of the future of long-term care. We should see both some of the problems that we have to solve and some of the solutions that we can look forward to as we in the Senate strive to make good on our commitment to maintain adequate health care for senior citizens. Our goal is to make it possible for senior citizens to remain as long as possible in their home and in their community, thereby decreasing the whole trend of legislation in the recent past which was to push senior citizens into costly institutional settings.

So I welcome you to this hearing of the Special Committee on Aging. I urge our witnesses to be as succinct as possible so we can get the maximum amount of participation from the audience. I call the first panel to the table before me: Irene Allan, Myrtle Monahan, William Waldman, George Legones, and Maureen Gilligan. This is the Middlesex County channeling project panel.

William Waldman and Irene Allan will have testimony, and we will ask questions of the other participants.

Let me say also at the outset that we are on a time schedule. So if I interrupt you and you haven't finished your testimony, it is not because I am not interested, but simply that we do have to move on in order to finish in the time allotted us. Your full testimony will appear in the record. Welcome to the committee.

PANEL NO. 1

STATEMENTS OF WILLIAM WALDMAN, EXECUTIVE DIRECTOR, MIDDLESEX COUNTY, N.J., DEPARTMENT OF HUMAN SERVICES, ACCOMPANIED BY GEORGE LEGONES, PROJECT MANAGER, COMMUNITY CARE FOR THE ELDERLY; IRENE ALLAN, SOCIAL SERVICE DIRECTOR, JACK PINCUS-UAW SENIOR APARTMENTS, NORTH BRUNSWICK, N.J.; MYRTLE MONAHAN, PROGRAM PATIENT; AND MAUREEN GILLIGAN, DIRECTOR, MIDDLESEX COUNTY, N.J., VISITING NURSE ASSOCIATION

Mr. **Waldman**. Thank you, Senator Bradley. It's indeed a pleasure to be here and it's great to have the opportunity to present testimony on this most important subject.

We are here, as you indicated, because we are 1 of 10 sites in the country to participate in the national long-term care channeling demonstration. We feel this is an innovative, community-based alternative to institutional care for the elderly.

To help with the presentation, I would just like to briefly introduce, to my immediate right, George Legones, our project director in Middlesex County; Irene Allan, who is the social service director of the Jack Pincus-UAW Senior Apartments; next, Myrtle Monahan, who is one of our clients I am delighted that could be here today; and, to my far right, Maureen Gilligan, who is director of the Visiting Nurse Association, Middlesex County.

Even though we are 1 of 10, I think we are further unique in the fact that our project—our intervention style—is a good example of public-private sector partnership in that many of the direct service functions of the project are contracted to the Visiting Nurse Association for direct care and service.

We became interested in a new approach to long-term care through our normal planning activities in the county through a number of basic facts which we uncovered. Several of those you have already mentioned, Senator, one of which, of course, even in Middlesex County with a population of 595,000, we witnessed the massive growth in the elderly population both in terms of their percentage of the population, their absolute numbers, and their increasing age.

Also, we realized with that the increased vulnerability, dependency, chronic illness, and functional debilitation that often goes hand-in-hand with aging. We also began to realize the tremendous demand for institutional care, waiting lists which approach the figure of 2,000 to 3,000 in the State of New Jersey at any given point of time.

In addition, our county undertook the construction of a new long-term institutional facility, which we expect will be filled very shortly and the demand will continue.

In addition, looking at the research literature, we realize that anywhere from 10 to 40 percent of the people currently in nursing homes can make it in the community if there is a viable package of services tailored to meet their individual needs.

In addition, we noticed what we feel is an insurance bias within the major public insurance programs of medicaid and medicare in that the big dollars, the major parts of the expenditures, are made for institutional care and community-based care, does not have that consistent, secure funding base that you attempted to achieve with your bill creating the title XXI.

And finally, and very importantly, that community-based care for the elderly, those variety of services like home health care, chore services, companionship services, and others are relatively fragmented within the community. There's no place that an individual who needs service can go to and get a package of services put together to meet their individual needs.

Often our office, and I am sure your office as well, had the experience of a family member or a senior citizen calling with many needs and it's so difficult to put that package together. Even professionals in the field have difficulty, and people who are under stress, and have the need to do it, it's even more difficult for them.

Finally, we believe locally that there had to be a more humane, more cost-efficient way to provide long-term care for the elderly, after many activities had culminated in our application process, and which we were very fortunately successful in partnership with the State of New Jersey.

Essentially a program, in some ways is very simple. It consists of several basic elements that I would like to highlight very quickly. One important aspect is that it affixes responsibility and account-ability to one individual and agency for the care of a person, and part of it is done through an assessment.

In other words, we have a professional staff equally balanced between nurses and social workers that do an overall social and health assessment of a client coming in to determine their strengths, their weaknesses, and what kind of care is appropriate for them.

From that assessment we develop a care plan which is an individually tailored package of services designed to meet the very unique, special, individualized needs of that person, and that person only. It might have a whole variety of in-home services that might include: home health, chore, companionship, physical therapy, perhaps out-of-home services, like adult day care, and others.

The care plan is participated in by the client and by the family members and one of the unique aspects of our project also is to provide encouragement and support for those significant others, those family members of the senior citizen, in developing the plan.

Finally, the very important thing is followup case management. The nurse or social workers who is assigned the responsibility for the family has the followup responsibilities, not to just make one referral and then leave, but to continue through to see that all the services in the plan mesh together to help maintain the person in the community, functioning at the highest level, in what is really the least restrictive environment.

Some other unique features are a research component. What I have just said probably doesn't sound very revolutionary to people who have been in the field and practicing for quite some time, but what's interesting about this is the cost factors, and the outcome factors will be systematically assessed on a research basis, and those findings will be available to the Congress and the administration as a tool to base further policy on.

Finally, because, as you mentioned so articulately, funds are shrinking very much for long-term care and one of the important things is it is nice to have a coordinated approach, a case-management approach, but we do need some dollars for services. There's nothing that will replace the availability of hard services for this population.

As a result, our program has a modest amount of additional dollars to secure those services for the individual when they cannot afford them for themselves, or they are not otherwise available within the community.

We have been operating this program for 4 months cooperatively with both the State of New Jersey and, as I mentioned earlier, our Visiting Nurse Association. And to tell you briefly about our 4 months of experience, our conclusions, some tentative findings, I would like to turn the microphone over to our project director, George Legones.

Thank you.

Mr. LEGONES. Thank you. I would just like to qualify my remarks by saying that this is a 3-year research and demonstration project. These are very preliminary observations on our part.

The first area is demand for service. I think that most of the statistics that have been mentioned today and are available, relate to the need for a community-based, long-term care system. We had the unique opportunity of observing the demand for this kind of service.

We have found when we opened our doors a very incredible demand. In the 4 short months that we have been operating with a very small intake unit, we have evaluated 400 requests for services, 200 of which have been found appropriate. And I want to say that our target population is very specific. It is a very frail population we are looking for, only those who would otherwise be in nursing homes if it were not for this intervention. And we experience a constant backup at our intake unit that we can't keep up with.

Senator Bradley. Have you made any conclusions about age?

Mr. Legones. So far the distribution has been equal. We gather statistics weekly between ages 65 to 75, 75 to 85, and 85 and above, and the referral rate is equal in those three groups. But I think that may change over time.

Two other observations about demand. Eighty-five percent of the individuals that had been referred are above medicaid eligibility level, 65 percent of those are between the community-based eligibility level and the institutional medicaid eligibility levels which are, of course, much higher in New Jersey.

Fifty percent of our referrals come from acute care hospitals, as would be expected, and home health agencies in the community, of which we have four.

As far as client outcomes go, we would say very strongly that the intervention is doing what it was supposed to do when it was initially conceived. The assessment instrument that Bill Waldman alluded to has been effective in identifying the full range of the needs of our clients. From this, we have utilized a very structured care planning process to address this full range of problems with the full range of services. This technique has been effective to date.

Most importantly, we have found that the case management element of the intervention has shown some remarkable results. The work of the case managers has been very good. They have been able to make very good use of the available resources in the communities. As their visibility increases, their ability to coordinate resources at the delivery level has become very effective.

I would also like to say that the case managers have identified a good number of clients. We have no statistics on this yet, but a good number who are not receiving the entitlements and the services that are due them, and they have, of course, spent a lot of time addressing these shortcomings.

Senator Bradley. The seniors in the home setting are not receiving the entitlements to serve them? For example?

Mr. Legones. Because the families of seniors just are not aware of medicaid eligibility, home health services under title XX, meals-on-wheels program that they might be able to get, and it is our case manager's knowledge of the community that has helped put those services in place.

I think when Irene Allan speaks she may be able to add to that with her experiences there.

And finally, and very importantly, we have increased the informal support participation in caring for an individual. It seems that if you offer a family some formal services they are more willing to provide the informal supports that help to round out the care plan.

From a systemic perspective, things have also been very encouraging. I was a little wary of this at first but the community agencies have been very willing to cooperate with us. From the certified home health agencies, to the Visiting Homemaker Association, the meals-on-wheels programs, the acute care hospitals, they have all done a lot to help us implement our channeling intervention.

Senator **Bradley**. Would you work through an example of a case?

Mr. **Legones**. All right. We would get a referral, let's say, from an acute care hospital, someone who has experienced some acute illness and will be discharged into the community, but really could not be unless there were a service package waiting.

We try to get the referral from the hospital as early as possible, administer the assessment to determine what the problems, strengths, limitations, needs are, develop the care plan and then, the brokerage activities which we have found have been particularly time-consuming, but effective, then take place.

The case manager just basically has to hustle around the community because we do not have a large amount of resources to purchase our own services. We have to use what is in the community and use informal supports that we can commandeer.

Senator **Bradley**. What do you mean by informal supports?

Mr. **Legones**. The informal supports would be family members, some relatives that may never have participated, may never have assisted———

Senator **Bradley**. You mean assessing the network of potential home support that exists in the community.

Mr. **Legones**. Exactly. Arranging for the services, as I was saying, is the most difficult. It is a lot of brokerage and advocacy work, and a lot of it depends on community relations because we have not instituted any systemic changes. The coordination is done at the delivery level.

Senator **Bradley**. How complicated is your assessment process?

Mr. **Legones**. Because it is for both research and clinical purposes, it is very complicated, I would say.

Senator **Bradley**. Is it possible to explain it to the Special Committee on Aging for the record? What do you do?

Mr. **Legones**. We assess every imaginable aspect of the client situation from physical environment, level of ability to do certain essential activities of daily living, instrumental activities of daily living, a little bit about income and resources, but there is no great emphasis on that because we do not have income restrictions on the program. Informal supports that are available.

Senator **Bradley**. How long does it take to make the assessment?

Mr. **Legones**. We are averaging about 1½ hours to administer the assessment, and sometimes that requires more than one sitting, depending upon the ability of the client to do it.

Senator **Bradley**. Are you finding that clients or patients have needs that you are not able to meet directly through your program?

Mr. **Legones**. Yes; I was certainly going to get to that. No matter how effective this kind of case management coordination at delivery level is, we don't have—what is missing from this channeling demonstration is enough of a resource to purchase the concrete services.

We are making, sometimes, miraculous things happen with volunteers, but there are certain skilled services and semiskilled services that just aren't available in Middlesex and, I am sure, the rest of the State.

Senator **Bradley**. For example, what do you do if someone comes into the program and what they really need is housing?

Mr. **Legones**. That is one of the most difficult ones in Middlesex County because our vacancy rate has always been zero percent. We do a lot of calling around. We have boarding homes, licensed and unlicensed. We have State sheltered health care facilities. We have a clearinghouse for living arrangements run by a community mental health center. A few resources like that would assist us in that regard, so the case manager wouldn't actually have to go looking in the paper.

Senator **Bradley**. Do you have any direct involvement with nursing homes?

Mr. **Legones**. We have not yet. We intend to—depending on how referral goes. The demand is so great now we have not had enough time to see about discharging individuals who are in nursing homes, although we have three or so that have actually been taken out of nursing homes and——

Senator **Bradley**. What about the other side of that, which is nursing home placement?

Mr. **Legones**. If an individual is too severely impaired to be cared for in the community we would certainly work toward nursing home placement.

Senator **Bradley**. But you haven't as of yet?

Mr. **Legones**. There may have been one or two cases.

Senator **Bradley**. Do you think that a channeling program and, by analogy the title XXI legislation, should have some control over nursing home placements?

Mr. **Legones**. Yes; absolutely.

Senator **Bradley**. And why?

Mr. **Legones**. So, that there would be that continuum of care. There would be easy access into the nursing homes from the community when it became necessary.

In answering your questions I have completed my testimony.

Senator **Bradley**. Let me ask just one other question. As you described this administrative structure it sounds somewhat complex, and my question to you is, Why is this? One assumes that it is because of the Federal Government's requirement that State health, and aging and social services all be involved. But do you have another explanation?

Mr. **Legones**. Yes; I am glad you asked that question. The Federal Government was not very happy that we subcontracted these functions out to existing community agencies. It has just been our policy as a department of county government, when there is an agency in the community with a good track record for providing certain services, we have used them rather than to create another level of government bureaucracy.

Most of the other sites are more centralized. There is really only one other that subcontracts out as we do, of the 10 demonstration sites across the country.

Senator **Bradley**. And subcontracting relates to you being able to identify who are the good subcontractors who have a good track record, right?

Mr. **Legones**. That is right.

Senator **Bradley**. You feel that is better than establishing a whole separate structure?

Mr. **Legones**. We do. And we are trying to prove that. All ten sites have certain variations.

Senator **Bradley**. We are all watching.

Mr. **Legones**. Right, we are indeed.

Senator **Bradley**. Let's go on.

Mr. **Legones**. I would like to turn it over then to Irene Allan, who is the social service director at a senior citizens complex and, as such, has had quite a bit of experience with our program to date.

Ms. **Allan**. I am very grateful for the opportunity to be here to discuss my experiences, not only just dealing with senior citizens' problems, but to support the community care program.

Prior to the community care program, when I had to deal with individual problems of the seniors in my apartment complex I had to, on a one-to-one basis, go to several different agencies.

Frequently, I would be cut off immediately because I do not have a medical education background so I was considered not qualified to make a referral. I had to stop at this point and go to the person's doctor, get the doctor to make the medical referral, and on, and on, and on.

The same thing with dealing with many of the financial agencies. Some of the personal information they needed I was not in a legal position to provide for them. I could not get assistance because I couldn't provide them with some of the personal information they needed. The tenant requiring assistance was not capable of doing it on their own. Adult child support—or other family support—may have been withdrawn at this point, so I had to stop efforts at this time.

In some instances, some of the tenants had several needs, but because they did not have enough physical impairment, they did not qualify for some services. If their incomes were $10 over a guideline, they did not qualify. They had to be poorer in order to get this particular kind of service.

In many instances, if a person was sick and poor, that qualified them for some service but because they were sick and poor, but were living in a subsidized housing situation they were considered as already receiving assistance, and further assistance was denied.

This is an example of the frustration and problems that I encounter. When I was able to deal with the children of my tenants and they were cooperative it made it a lot easier.

Frequently, I find a great deal of my job is also social service work to the children of the tenants because, again, they can't on their own, find a source to support and inform them where resources are to help their parents, grandmothers, aunts, and uncles.

Frequently, as a result of the frustrations they experience, they would give up. There have been people in my building who have been abandoned by friends or relatives, not because they don't care for the person but because they just couldn't cope or didn't know how to cope with the problems. Had no place to turn to to find out what they should do or where they should go for help.

One of the best examples of how much good this program has done is the lady that is sitting next to me. Three months ago, even with my own experiences of dealing with problems of senior citizens, I was ready to say very definitely, yes, Myrtle Monahan should be in a nursing home.

She had lost quite a bit of her family support. She was very disoriented. She started to depend completely on other people in the building. You had to go every day and get Myrtle out of bed, otherwise she just wouldn't function. I started having to deal with her on a daily one-to-one basis.

I found she was taking all kinds of medications prescribed by at least four to five different doctors. Finally, I was able to obtain from her who her original doctor had been. When I called him and he found out she was dealing with all these other doctors, and on all these other medications, he was astounded.

I got her to the doctor, got her off at least 50 percent of the medications that she was on and started to see some slight improvement in her condition. She indeed was not senile, she was overmedicated.

Her friends and family did not know this. I did not know it to begin with and, like I said, was ready to see that she be put in a nursing home. Because the overmedicating had gone on for such a long time, she needed help in other areas.

She had not been able to maintain her housekeeping. She couldn't go out anyplace on her own and shop and it was going to be some time before she was in stabilized enough condition that she could again do these things.

Now, if I had had to go to each agency myself and try to get this kind of help——

Senator **Bradley**. What kind of help?

Ms. **Allan**. A housekeeper, somebody to accompany her to a grocery store, someone who might come in with her a couple of hours a day just to see that she was taking the proper medication. By the time I would have eventually found these type of services she indeed probably would have been in a nursing home because she couldn't have functioned as she was.

This all happened 3 months ago. Myrtle is 87 years old. She is now baking, she is crocheting. When I talked to her about coming here today what she said to me was, "I'll be happy to go and we're going to give them hell," and that is exactly what her words were.

Senator **Bradley**. Does Ms. Monahan want to say anything?

Would you like to say anything?

Ms. **Monahan**. Well, they have been very good to me and Irene has been very good. I was in awful condition, but she met me and the nurses and all of them from the agencies were very good to me. They had taken me to Dr. Zamarody to have me examined to see if I was crazy. And she said, "No," I was far from it. But she said I need medical care, and she had given me things to take, and I take them night and morning. And Irene has been very, very good to me, attentive to me and I have got an awful lot to thank for.

Senator **Bradley**. So you essentially heard about this program through Irene?

Ms. **Monahan**. Yes.

Senator **Bradley**. And then the question is how did you hear about the program, Irene?

Ms. **Allan**. I heard about the program initially from George Legones. He and I both attended a service providers meeting. And he gave a brief description of his program and what was involved. Also, a lot of the people that are dealing with his program, caseworkers, are people that I had known when they were coming into, my building as visiting nurses, giving aid and assistance to some of the tenants.

Senator **Bradley**. So you are the only person who actually deals with Ms. Monahan?

Ms. **Allan**. I am not the only person that deals with Ms. Monahan. I am the only person that is making some interventions for Ms. Monahan at this time because her family, again, did not have the resources, or the knowledge to do this for her.

This, again, has been a situation where the family is a lot more comfortable knowing that she is getting better, and they are being more attentive because she is able to do more on her own. Also, I was able to make the referral to George Legones' program.

Senator **Bradley**. And what did you do, George, when you got the referral from Ms. Allan?

Mr. **Legones**. My direct service contact is limited but the caseworker assigned to the case did very much what I described before; assessment, care plan——

Senator **Bradley**. She was referred to you by Ms. Allan, you made an assessment and developed a care plan and then tried to broker the arrangement?

Mr. **Legones**. Exactly right.

Senator **Bradley**. Very interesting. Very helpful.

Ms. **Allan**. Some of the assistance I received I had already made referrals, but if it had not been for the intervention of George and his caseworkers I know I would not have gotten those services as quickly as I did.

Senator **Bradley**. Is this costing any more money or is this simply a better use of available services?

Ms. **Allan**. I would like to support George's statement about subcontracting to other agencies. I do think it is making better use of services that are already available. A lot of the agency people that came to see me were much more thorough and just seemed more willing to do a better job because they had been bolstered a little bit through George's program.

Senator **Bradley**. And what are the specific services that are now being utilized by Ms. Monahan?

Ms. **Allan**. At the present time, she has a companion-type homemaker who is coming to her a couple of days a week. COPSA has provided some service here. When Myrtle spoke of Dr. Zamarody, Dr. Zamarody is a psychiatrist with the community outreach program for senior adults. Again, because there was a medical person involved in the original assessment that the community care did, they were able to talk directly to Dr. Zamarody and she came out to deal with Myrtle and her problems, provided her counseling and medication to help her get over some of her problems.

Senator **Bradley**. Fine, thank you.

The last person on the panel is Maureen Gilligan.

Ms. **Gilligan**. My remarks will be very limited, just to support what George Legones and Bill Waldman have said. It has been a very good opportunity for the Visiting Nurse Association to be involved with the channeling program, and we have been supportive of it from the beginning.

As far as our staff is concerned, it is a continuation and an outreach of something they have been wanting to do for a long time, being able to provide those services on a more comprehensive basis.

Senator **Bradley**. Let me ask the panel as a whole, and any of you can volunteer, what services do you feel are most critical to your older patients' ability to remain in their home? Can we say that after 4 months, or should we hold the hearing in another year?

Mr. **Legones**. We do have one case manager here. I should put her on the spot, but I won't. The 2 hours of home health services in the morning that can get reimbursed from medicaid in some instances is very important, but we found that that 6 hours, perhaps when that significant other is not in the home, is the most difficult thing for us to get, lesser skilled but very important custodial care.

If I had to cite one thing after 4 months of operation, that would be it.

Senator **Bradley**. That is what additional service you need?

Mr. **Legones**. Yes.

Senator **Bradley**. And that simply is day care operation essentially?

Mr. **Legones**. Right.

Senator **Bradley**. Have you seen many circumstances in which you had a household in which there were two generations living together, both of which need the care; say, a 75-year-old taking care of a 95-year-old?

Mr. **Legones**. Yes; we have a small percentage. I couldn't really tell you offhand, but, yes.

Senator **Bradley**. What percentage of your older patients have no family close by?

Mr. **Legones**. Twenty five percent, thirty at the most.

Senator **Bradley**. Twenty-five percent.

Mr. **Legones**. There is more than you think that have someone within maybe the next town, but have not wanted to deal with their elderly relative, for whatever reason, in a number of years.

Senator **Bradley**. And this is over a number of years.

Mr. **Legones**. But our case managers are very good nudgers. They manage to get them more actively involved.

Senator **Bradley**. I think this has been very helpful and I thank the panel very much for your statements and your contributions. As we look at this whole issue the question is going to recur about whether the delivery system can be so designed so that you have some legitimate sense that you actually can get what you need. You have to know what services are needed, and you have to have some sense that the system is able to deliver them, and then you have to be able to put a cost on that.

What you are doing in Middlesex County is something that I personally am going to look at very carefully as title XXI, hopefully, moves along the legislative path toward adoption.

Thank you very much for your statements.

[The prepared statements of Mr. Waldman, Ms. Allan, and Ms. Gilligan follow:]

PREPARED STATEMENT OF WILLIAM WALDMAN AND GEORGE LEGONES

INTRODUCTION

As one means to address the growing concern over the long-term care needs of the elderly, the county of Middlesex applied for and was awarded a Federal contract to participate in the national long-term care channeling demonstration (NLTCCD). NLTCCD represents an effort on the part of the Federal Government to test a community-based alternative to institutional care for individuals 65 years of age and older with chronic health and social care needs. The local project, one of 10 nationwide, is called community care for the elderly (CCE) and is administered out of the Middlesex County Department of Human Services.

PROJECT SUMMARY

Simply put, CCE is attempting to comprehensively and definitively test the concept of case management as a viable approach to preventing or postponing unnecessary institutional care. The project, in fact, is designed to serve only severely impaired individuals who, in the absence of such an intervention, would be institutionalized. CCE provides comprehensive assessment, care planning, and case management services to those individuals in an effort to effectively orchestrate an array of formal and informal services which would be necessary to maintain that individual in his/her own home. Basically, an individual who is screened and found appropriate for CCE is given a comprehensive assessment to identify health and social problems, strengths, limitations, and service needs. The findings of this assessment are then used to develop a plan of care which sets forth the types of assistance required by the client. The care plan is developed by a specially trained case manager with either a nursing or social work background. This care plan is developed with the active participation of the client and his/her family.

Once developed, the care plan is reviewed by a case manager from the opposite discipline. That is, if the original case manager has a social work background, the care plan would be reviewed by a peer with nursing experience and vice versa. This process allows for a comprehensive and holistic approach to meeting client needs. The care plan is then approved by all parties involved and the case manager takes all necessary steps to implement the care plan. This process takes various forms depending on the particular situation.

In addition to this general description, several important aspects of this intervention are worth highlighting. First of all, there is a constant emphasis on cost-effectiveness in developing care plans. Case managers must make the most out of existing community resources, family, and volunteer support systems. CCE does not include unlimited resources with which to purchase gap-filling services and must, among other things, prove to be cost-effective.

Second, the design of CCE specifically addresses the need to balance the provision of health and social services. Although the assessment and case management component is being provided through subcontract by the Visiting Nurse Association of Middlesex County, a primary health care agency, the structure of the intervention fosters balanced care plan development. The staffing patterns of professional nurses and social workers organized into informal teams assures that one service type is not over- or underemphasized.

Another important aspect of the intervention involves the specificity of the target population. CCE is serving only those individuals who are functionally impaired to the point where nursing home care would normally be indicated. This is important in that any benefits that might be realized through the intervention with respect to prevention of institutional care would be invalidated if the client group was not truly at risk of institutionalization.

Finally, the importance of the research component cannot be overemphasized. In the past several years there have been a variety of channeling-type projects, several of which have had limited evaluation components. NLTCCD has a very comprehensive and intensive research component. Each of the 10 projects, including CCE is being carefully evaluated as per service utilization, cost-effectiveness, and, most importantly client outcomes. The evaluation is being conducted by Mathematica Policy Research, Inc. under contract with the Federal Department of Health and Human Services. In this way we hope to demonstrate definitively that a viable alternative to institutional care is not only possible, but feasible and cost effective.

PRELIMINARY FINDINGS

CCE has now been operational for just over 4 months. Although it is too soon to present any formal evaluation results, we would like to share some early findings.

DEMAND FOR COMMUNITY BASED LONG-TERM CARE SERVICES

Most of the studies regarding long-term care present various estimates of need. These estimates usually suggest that between 2 to 14 percent of the 65 and over population require long-term care services. The best information available regarding demand is specific to the demand for medicaid eligibles for nursing home care. We have had the opportunity to witness the actual demand for a community-based alternative to institutional care. In 4 months of operation with little generalized outreach we have experienced more of a demand for help than we can handle. Despite the research design, our restrictive appropriateness criteria, and limited capacity (we are staffed to serve a 500-client caseload maximum), we have had to restrict intake in order to deal effectively with the referrals already received. During these 4 months, we have handled over 400 requests for services, identified over 200 appropriate clients, and have a constant backup at intake.

Also, with regard to demand, we have found that over 85 percent of referrals have incomes above medicaid eligibility levels and that the majority, 50 percent, are identified and referred by staffs of acute care hospitals and home health agencies. It has also become evident that most families that seek nursing home placement for an aging family member do so because they lack feasible alternatives and are very pleased that one now exists.

PROJECT BENEFITS AND CLIENT OUTCOMES

Early experience with this case management intervention is very encouraging. Even with the restrictions inherent in the research aspect of NLTCCD the intervention is doing what it has been designed to do. Community services both formal and informal are being coordinated at the delivery level in such a way as to enhance the independent functioning of elderly who might otherwise be institutionalized. Several specific indications in this regard are as follows:

Client assessment.—Many times a client or family may not be fully aware of the medical and social problems which result in functional impairment. The NLTCCD assessment instrument and process has been effective in identifying these problems so that they might be properly addressed.

Care planning.—CCE has had early success in utilizing assessment findings to develop comprehensive care plans. The structured approaches used by CCE insures that all problems are addressed, not just surface issues.

Case management.—Implementation of the care plan represents perhaps the most important part of the channeling intervention. Specially trained CCE case managers who are knowledgeable of existing resources, eligibility criteria, and application procedures have been very successful in maximizing these resources for the client's benefit. It is also readily apparent that, for the most part, the clients we have been serving had not been receiving certain entitlements and services for which they were both eligible and appropriate. Client impairment and fragmented delivery systems are the primary reasons for this underutilization. Further, case managers have been successful in increasing the participation of family members and other informal supports with the provision of care.

SYSTEMS ISSUES

The administrative experience we have gained implementing CCE in Middlesex County has been invaluable. In dealing with the various agencies and programs which have been established to address long-term care needs, we see on a daily basis that much of this fragmentation and duplication is unnecessary. Service providers are, for the most part, more than willing to do whatever is necessary to aid an eligible individual, but can usually only address part of the overall problem. CCE has been able to effectively coordinate provider activities at the delivery level. Only the research component is preventing project administration from attempting more systemic changes. Problems and strategies, however, will be duly noted for possible implementation once the research is complete.

SERVICE GAPS

Although the early feedback from CCE is certainly positive, we cannot deny that service gaps are inhibiting the program's effectiveness. In many cases where informal support systems are fragile and personal resources limited, it is difficult to develop a workable care plan. This problem is most severe for, but not limited to clients who are just above the community medicaid eligibility level. These individuals are not eligible for reimbursement for essential skilled care services on a long-term basis.

A second major service gap issue involves the nonexistence of less skilled yet critical support services. Chore and companionship services, for instance, simply have no stable funding base, yet can mean the difference between community and institutional care. Access services are also difficult to secure and critical to continued independent functioning. Specialized transportation, for instance, can prevent an individual from utilizing a critical institutionally based service. These and other service gaps can often be addressed, to a degree, by coordination at the delivery level, but the need for changes in Federal and State legislation and policy are being clearly identified by the channeling demonstration.

CONCLUSION

Although we are as yet too new to present the concrete statistical evidence that can show definitely the effectiveness of this type of intervention in preventing the institutionalization of the frail elderly, our early experiences are encouraging. We are confident that NLTCCD will clearly demonstrate that case management is a critically needed, viable, feasible, and cost-effective alternative to institutional care. Further we expect that the channeling project will specifically idenitify systemic problems that could be addressed in order to improve the existing delivery network. As such, we sincerely hope that Congress will consider these findings and initiate the necessary policy and legislative changes which would foster the development of a national community-based long-term care initiative.

Prepared Statement of Irene Allan

REFERRALS MADE TO THE [illegible]UNITY CARE PROGRAM

In the apartment complex where I function as social worker, 238 senior citizens reside. Fifty percent of these people require the very minimum need of my assistance. The other 50 percent require more attention in varing degrees. Generally I, with the cooperation of their families, can handle most of the problems. However, in cases where family support is withdrawn, or there has not been any, the problems sometimes become so complex, that in order to best provide services for these individuals, I must get help from various agencies. Prior to the existence of the community care program this was not an easy task. The amount of redtape, and other obstacles I would encounter, prevented me from obtaining the proper help in the amount needed and time needed to prevent personal disaster.

When the program came into being I was quite skeptical, I had seen other programs come and go. I can't tell you how pleased I was to discover that this was one that delivered all that it claimed. The following are individuals who were referred to, and received help from the program.

Myrtle Monahan (present at hearing).—Myrtle has resided in the apartment complex for 2 years, during this time received attention of family and friends. She was active in building functions and community functions. Other than some physical problems including slight deafness, she was doing well. It was soon obvious that she had developed other problems. She began isolating herself. According to her family her physical well-being had deteriorated and she could not be as active. I began to see less and less of her family. Other tenants informed me she was becoming dependent on them. She began making frequent calls to the rescue squad to take her to the hospital, only to be returned home because there was nothing wrong. She was showing all signs of becoming senile. I called her family and tried to get them to continue helping her. They informed me they could not cope with her problems and felt she should go to a nursing home.

In the meantime I had to provide help for her. I discovered she was taking several medications from several different doctors. I called her doctor who had been treating her in the beginning and found he was not aware of all the medicines. After he examined her and determined a great deal of her existing problems were due to overmedicating, we were able to begin to help her. Her problems needed more attention than I could provide. Community care was able to get a homemaker. Referral to COPSA for help to deal with her emotional problems. Help though other agencies to straighten out some of her financial problems. As a result of the attention and assistance, Myrtle has become interested in herself again. She has become active and concerned about herself and her surroundings and is now able to maintain herself in an independent living situation with the very minimum amount of assistance.

Margaret Dufford (78 years old).—Also a resident for 2 years. In Margaret's case, her family insisted on dealing with her problems, and did not want interference. For a period of 1 year she kept to herself, did not participate in building functions, or make friends with other residents. Spent a considerable amount of time at her daughter's. When she became more noticeable around the building her appearance was not good, she seemed very confused, and disoriented. When I asked about her family she told me they didn't want anything to do with her. I called her daughter who said she didn't know how to deal with Margaret's problems and I should do whatever I felt best. It was at this time I realized her family had not been taking care of her, but using her to provide housekeeping and babysitting services for them. I also suspect, due to her appearance, there were incidences of adult abuse. In Margaret's case it was start from scratch and rebuild her lifestyle. With the assistance of community care she was provided with services to help her physically, emotionally, and financially. She is still a long way from being able to maintain herself as well as Myrtle, but with ongoing assistance will be able to do so eventually.

Sophie Gerber (68 years old).—Resident for 2 years. Completely independent person. Very active both in and out of the building. About 4 months ago she had what appeared to be a stroke. Results of tests, including a brain scan, showed she had inoperable brain cancer. The rate of this person's disintegration was unbelievable. Her doctors and family agreed for her best interests she should be maintained at home. Her family in this instance received the benefits of community care. The program provided them with resource information that enabled them to provide for their mother's needs.

I would like to point out at this time that others have been referred to the program, but have not been accepted at this time. Rather than be discouraged by this, I was impressed that the assessment procedures were so thorough that those who had the greatest needs were the ones selected for help. I can't say enough for this program. The far-reaching benefits are numerous. I am listing those I feel are of great importance.

(1) Provides a form of crisis intervention.

(2) Speeds up processing and gets through much of the redtape in dealing with other agencies.

(3) Provides professional caregivers assistance. In my case allows me to service all the people in my care, and not have to concentrate on just a few. Let's me do preventative social service.

(4) Provides adult-child caregivers a source of information, and intervention, and most important morale support.

(5) Does a team assessment. Takes into consideration all the needs of the individual. Does not limit service on a medical or financial basis. Does the assessement on one-to-one basis with the client in the client's home surroundings. Giving the program a truer picture of the client's needs, and making the client more comfortable.

(6) Services provided, follows through. Continuing checkback to be sure its working.

(7) Saves lives, money, and pride. Keeps our elderly in an independent living situation. They can continue to be of service to themselves, and to their community.

Our senior citizens deserve the best we have to offer. They have contributed a great deal of their lives servicing us. I feel this program is part of the best we can offer. To Bill Waldman, George Lagounis, Elsie Carter, Antonio-Colon Garcia, and the countless others who have worked so hard to make this work, I want to thank you for me and my seniors. I hope you get full speed ahead on this one!

PREPARED STATEMENT OF MAUREEN GILLIGAN

INTRODUCTION

In response to the future problems anticipated as a result of the rapidly increasing over-65 population and the skyrocketing cost of nursing home care, the Federal Government has established the national long-term care channeling demonstration project. The project is designed to provide an alternative to institutional care for individuals over 65 years of age with long-term care needs. The channeling demonstration is based on a concept of case management whereby a professional and further specially trained case manager works with a client and his/her family to comprehensively assess individual needs and develop, arrange for, and monitor a package of services which best address these needs. The project also has a research component which heavily impacts on a number of key elements of the assessment/case management process.

ORGANIZATION AND STRUCTURE

The Federal Government contracts with the State of New Jersey. The State in turn subcontracts with the Department of Human Services in Middlesex County for administration of the local project—Community Care for the Elderly. The county has engaged the Visting Nurse Association in Middlesex County as a second tier subcontractor for the assessment and case management of channeling clients. The county also contracts with the local medical assistance unit (LMAU) for screening functions.

CLIENT FLOW

Clients wishing channeling services contact the screening unit. A screen designed primarily to detemrine functional disabilities and, therefore, likelihood of nursing home placement, is administered to the client or a proxy acting on his behalf. If the results of the screen indicate sufficient disabilities in areas of activities of daily living and instrumental activities of daily living the client is determined to be appropriate for the program. Since channeling is a research project, there is a control group component to the project. The names of the appropriate clients are called into Mathematica Policy Research (the company responsible for the research component). MPR randomizes the appropriate clients and makes a determination as to who is a client and who is a control group member. Control group members do not lose any benefits or service which would have ordinarily been available to them. They do not, however, receive the case management services of Community Care for the Elderly.

The names of those individuals designated to be in the treatment group are then reported back to the screening unit. The screening unit refers the clients to the case management unit. The case management unit, under the executive director of the VNA, is composed of a program director (a nurse with public health experience), a supervisor (a social worker with public health experience), nine case managers, a clerk, and a secretary. Five of the case managers are social workers. Four of the case managers are nurses with public health experience. Each case manager is assigned a segment of the county and she is responsible for those clients within that area. Both the social worker and the nurses perform the same assessment/case management functions and have the same job descriptions.

Once a referral is received at the case management unit the supervisor assigns the case according to area. With the ever-increasing cutbacks in funding for services to the elderly, it is absolutely essential that a case manager be totally familiar with every resource, either formal or informal, available in a community. Thus, as the case managers are primarily responsible for only a segment of the county, they can more fully familiarize themselves with the resources in their area.

The case manager makes a home visit to assess the client. The instrument for assessment in current use is one designed to meet both the clinical and research needs of the project. Although the assessment adequately covers the critical areas needing to be evaluated with each client, it does have certain drawbacks associated with its dual purpose. Primary among these is the 52-page length of the instrument. Once the case manager completes her assessment in the home, she begins contacting individuals or organizations currently involved with the client. In this way she fills out the information obtained from the client or his proxy. The case manager completes an assessment summary which is a clinical rather than research tool.

With the assessment phase completed the case manager enters into the care planning phase. While keeping in frequent contact with the client the case manager identifies problems, establishes desired outcomes and determines the resources available to that client that will help him reach those desired outcomes. The case manager contacts those potential sources of assistance, whether home health agency, mobile meals program, transportation program, volunteer group, neighbors or family, etc., to establish their willingness and ability to assist. The care plan is reviewed with the client. If the client is in agreement he signs the care plan. The case manager then finalizes her referrals to the sources of assistance outlined in the care plan.

The monitoring phase then goes into effect. The case manager determines if the individuals and organizations actually start service, if the service being provided is that which was requested, if the service is meeting the clients needs, if the client needs are changing, and if the client is satisfied with the service.

The client is periodically reassessed and adjustments are made in the care plan according to the results of the reassessment.

IMPACT OF CHANNELING

The plight of the frail elderly individual struggling to maintain community living is complicated by a number of factors.

The system of home care delivery is an extremely complicated one. Knowledge of existing resources is an area of which even dedicated professionals must strive consistently to stay abreast. In just the past few months Middlesex County has seen channeling come, the senior companion program come, adjustments in benefits allowable under medicare and medicaid, a new home maintenance organization come, code 70 or medical assistance to the aged go, cutbacks in title XX funds, just to mention a few. The frail elderly, not being social service professionals, many of whom have limited education, and faced with the very real prospect of declining mental functions could not possibly be expected to be aware of what all exists in the way of help.

Aside from being difficult to identify, resource can be impossibly complicated for the debilitated older person to access. At times, knowing where to call, who to talk to, and what to say aren't even sufficient. Frequently obtaining the right form and filling it out the right way can be an obstacle that is totally insurmountable. Especially sad is the problem when it means the individual gives up and goes in a nursing home rather than try to find his way through the home care maze any longer.

For those lucky enough to have identified and accessed the services they need, there are still pitfalls ahead. The system is so uncoordinated that it is not unusual for one service to be oblivious to the presence of another service involved in a case. Thus, it is not hard to imagine the elderly client with three or four providers on his doorstep in one day, while on another day even his basic human needs may go unmet.

A common problem can occur which an elderly person in his drive "not to be a burden" creates for himself. The elderly are frequently fearful to call out and ask for help. So often is heard, "I can't ask my friends, neighbors, children, they've got their own lives." Rather than place demands on another's time, many elderly will tolerate poor or even inhuman conditions.

The skillful case manager is up to date on the resources, can cut through the redtape of access, can align services to provide the broadest possible coverage and can assist the client to marshal his informal resources in a way that prevents rapid burnout of care given.

To illustrate the role of the case manager in the Community Care for the Elderly program, two case scenarios are described below:

Mrs. G. is a 70-year-old woman who had been admitted to a nursing home after a fall resulting in a fractured coccyx. She also has a history of high blood pressure, diabetes, an enlarged pituitary gland, and arthritis. She and her husband had lived together in a two-story home prior to her nursing home placement. They were very unhappy about Mrs. G. being in a nursing home but her husband was fearful of assuming the responsibility of bringing her home.

The client, if she went home, would need help with getting in and out of bed, dressing, bathing, toileting, and heavy housework. Neither the client or her husband had used formal services for home care in the past and had no knowledge of how to go about making arrangements for home care.

With the assistance of the case manager the following plan was established:

Husband: Housework, laundry, and shopping—weekly; medication administration—as needed; dressing and bathing—weekends; meal preparation, toileting, transfer, and ambulation—as needed.

Home health aide: dressing, bathing, toileting, transfer, and ambulation—3 hours, 3 times a week. The home health aide is funded by medicare.

Occupational therapists: Instruction in independent activities daily living—2 times a week. The occupational therapist is funded by medicare.

Nutrition site: Preparation of main meal (picked up by husband)—5 times a week.

Neighbor: Preparation of main meal—2 times a week.

Senior companion: Companionship and respite for husband—4 hours 2 times a week. Senior companion program is funded by action grant.

Eldercare: Referral for a physician who would make home visits—as needed.

Visiting nurse: Monitoring instruction—1 time a week. Visiting nurse's are funded by medicare.

With this plan established in advance of nursing home discharge, the husband felt sufficiently reassured to go ahead with plans to take his wife home. On May 20, Mrs. G. came home. She and her husband are happy and managing well. This care plan represents a public cost savings of about $600 per month as compared to the cost of nursing home care.

Mr. S. is a 92-year-old man with advanced senility, chronic myocadnitis, arteriosclerotic heart disease, bilaterial inguinal hernia and hypertension. Mr. S. was a very active independent person all his life. He and his wife moved in with their daughter 2 years ago as their health began to fail. He has recently been very agitated, depressed, and angry, with one episode of psychosis. The daughter is 61 years old and has severe arthritis. She has been feeling isolated and forced into devoting all of her time to the many needs of her parents. However, any attempts she's made to seek assistance in their care has resulted in anger from her father and mother. She was, therefore, feeling guilty and although she was becoming increasingly nervous, she was resistant to assistance.

A plan was established whereby Greta, the daughter, would continue to assume responsibility re: household chores and some personal care for her parents. She was also encouraged to attend a "caregivers support group" so that she could meet and talk with others facing the same problems as she. Another daughter was involved for assistance with personal care and money management to take some of the burden off Greta.

A companion from the senior companion program was arranged for 4 hours 2 times a week to allow the daughter some time to herself and to provide stimulation for Mr. S. Transportation to the physician was arranged through the assistance of the companion.

When last visited the daughter was more relaxed and better able to bear up under the still heavy demands placed upon her by her parents. She had not only taken advantage of the respite provided by the senior companion, but also arranged for additional respite on Saturdays on a private pay basis. Her father has been very happy with the male senior companion and looks forward to his visits. Had the home situation continued as it had up to the point channeling became involved, nursing home placement would have been inevitable for Mr. S. and his wife. As it is, they continue to live happy satisfied lives in the home of their daughter. This is being done at a public cost saving of about $1,000 per month when compared with nursing home cost.

IMPACT OF CCE ON MIDDLESEX VISITING NURSE ASSOCIATION

Twelve of the cases currently being served by Community Care for the Elderly were referred by the Visiting Nurse Association. The actual number of referrals by VNA staff is considerably higher than that figure, however, a certain number of those clients were assigned to control group or determined inappropriate for the program. There have been approximately 16 cases referred by Community Care for the Elderly for home health care from one of the surrounding home health agencies.

Although experience with this number of clients does not provide sufficient data on which to base firm conclusions, there have been some effects of joint VNA-channeling involvement that could be indicators of benefits to be derived.

Channeling involvement can mean better utilization of the VNA staff nurses time. The case managers intervention in identifying needs, developing plans to meet those needs, making referrals, and following up on the results of the referral, can free up the nurses' time to concentrate her skills in the area of nursing care.

There has been in some cases, an added advantage to the visiting nurse when the case manager becomes involved with a client prior to hospital or nursing home discharge. The case manager is at times able to set the stage for the client's return to the home, so that when the nurse does admit the patient arrangements for other services (i.e., home delivered meals, equipment, companion services) have already been made.

When gaps and problems in services to a client become apparent the nurse can turn to the case manager for help in resolving the issue. The case managers have both the time and the expertise to resolve some of the more difficult problems of home care delivery. Visiting nurses are frequently faced with the difficult decision to terminate a case because of lack of skilled care needs, yet they are acutely aware of the clients need for monitoring and the real possibility that the package of services in place at time of discharge will not be appropriate for that client indefinitely. Cases which have channeling involvement can free the nurse of these concerns, since she knows there will be someone who cares and is responsible for the client after nursing discharge. Although it is too early to make any hard statements, it is expected that there may be a shorter length of VNA service to channeling clients because of the case management services to be received by the client.

ADVANTAGE OF VNA-BASED CHANNELING

By nature of its very definition aging is a condition of the body. The frail elderly, with whom the project is concerned, are those aging individuals whose bodies and/or minds have been more severely affected by the aging process. Therefore it is extremely likely that many of the frail elderly will be in need of home nursing, physical therapy, speech therapy, and occupational therapy. The obvious health aspects of home care for the elderly make a certain amount of medical expertise a necessary characteristic for case managers.

Home health agencies have a long history of service to the elderly in the home, certainly more experience than any other existing private or official provider. It is obvious that: (1) Home health agencies are extremely likely to be involved or needed in a high percentage of cases requiring channeling-like services. (2) Home health agencies have an expertise that could easily be redirected toward channeling-like functions.

In relation to assessment, the public health nursing assessment of a patient need only to be added to in a few areas to be a comprehensive assessment approach for channeling-like purposes. However, to have an assessment lacking in medical input creates a situation in which the assessment is likely to be incomplete. The training needs of the nonregistered nurse assessor who does not have easy access to medical consultation are so extensive as to make their use impractical.

Neither the case manager nor the visiting nurse can function without doing an assessment. It would seem that there are advantages in terms of not duplicating assessment processes by having one agency responsible for the entire assessment. When two agencies are involved, it can reasonably happen that the two assessments produce two entirely different sets of conclusions. Thus the dilemma is created of who is right.

In many respects the care planning currently being done at VNA's is similar to the care planning done in CCE. CCE is better equipped than home health agencies for long-term care planning, however, there is undeniably a strong base already existing in VNA's on which to build. It has been our experience that the public health nurse adapts readily to the long-term care planning of channeling.

Another advantage to channeling-like functions being situated in a home health agency is the easy access provided to the staff nurses and their supervisors. The ability to sit down face to face with nursing staff involved in a case has proven to be extermely valuable in terms of coordination and problem solving in many of our cases.

REPLICATION OF THE PROJECT

With a central administrative unit on a governmental level, channeling could easily be replicated throughout the State for the following reasons:

Home health agencies across the State have a pool of experienced nurses and social workers already heavily involved in the care of the elderly. It would be relatively easy to establish a separate assessment/case management unit within these agencies.

Home health agencies' assessment instruments could be easily added to or modified to meet the needs of a channeling-like project.

VNA's are already equipped to handle data and billing demands that such a project would warrant.

Several additional factors that need consideration in speaking of replication:

It is advisable to have a distinct unit to handle long-term care assessment/case management within an agency. Long-term care is frequently equivalent to chronic care. If the long-term care client must compete for priority in receiving service with the acute care client, he will frequently be placed lower on the list.

Some degree of control of resources by case managers is essential. Although at CCE we have been very pleased with the cooperation received from community agencies, case managers are somewhat handicapped by their inability to make decisions and commitments relative to funding for certain services.

Guidelines for expenditures shoud allow the case manager flexibility and room to seek creative solutions for problems. If, for example, structural barriers in a home are making it impossible for a client to be independent in bathing, the long term, less costly, and most effective way of dealing with the problem may be to do away with the structural barrier rather than provide a home health aide for bath service.

The time for long-term case management has definitely come. The need for building a case management system that utilities the expertise and resources currently avaliable is obvious. We at the assessement case management unit of the VNA in Middlesex are hopeful that channeling-like programs become nationwide in the future.

Senator **Bradley**. Our next panel is from Union County and is composed of two members: Peter Shields, director, Union County Office on Aging, and Rosemary Cucarro, executive director, Union County Visiting Nurse Association.

Let me welcome you to the committee's hearing and ask you to begin your statement.

PANEL NO. 2

STATEMENTS OF PETER SHIELDS, DIRECTOR, UNION COUNTY, N.J., AREA AGENCY ON AGING, AND ROSEMARY CUCARRO, EXECUTIVE DIRECTOR, UNION COUNTY, N.J., VISITING NURSE AND HEALTH SERVICES

Mr. **Shields**. I am going to read my statement for less than 5 minutes and then I am going to have Rosemary Cucarro, my good friend and partner, give you some details on the specific home health care program that we are involved with and some cases.

My name is Peter Shields, and as director of the Union County, N.J. Area Agency on Aging for the past 10 years, immediate past president of the New Jersey Association of Area Agencies on Aging, and former legislative chairman of the National Association of Area Agencies on Aging, it amazes me that we do not have a better home care system in this country.

Prior to my current position, I spent over 30 years in Federal service, mostly as a field representative of the Social Security Administration where I saw thousands of disabled elderly in their homes, many of whom did not receive adequate medical care.

When we started our area agency in Union County we were initially feeding 40 homebound elderly through meals-on-wheels. Today, we are providing over 500 meals daily to over 400 sick at home. In addition, we are providing through a combination——

Senator **Bradley**. Excuse me. It went from 40 per day to 500 per day?

Mr. **Shields**. In a 10-year period.

In addition, we are providing through a combination of title III and title XX dollars, thousands of nursing visits and home health aide hours to the homebound. We are also involved in more than a dozen other programs covering hospice care, the elderly blind, legal services, and so forth. I look today at the complexities of titles XVIII, XIX, XX, title III and private health insurance coverages, and wonder when we will do a better job in tying it all together. In

Union County, we have a pretty good coordinated system going on home health care. However, we need the improvements that new legislation can give us.

We concentrate our efforts on the sick elderly poor with accent on five major elements of home care: home-delivered meals; nursing visits; home health aide hours; medical transportation; and trained, competent social workers.

In doing this we work closely with all the public and private agencies in the county that are concerned with the elderly. We run the Union County Nutrition Program for the Elderly, providing the home-delivered meals.

This year we revised our approach to the visiting nurse and home health aide agencies by retaining at the area agency a pool of title III dollars that are combined with all the title XX home care dollars that formerly went to county welfare and private nonprofit agencies.

These combined funds are then made available to the servicing home care agencies who bill us on a per patient basis. The home care agency does the case management and coordinates other related services for patients, such as our home-delivered meals and medical transportation.

I first heard a proposed title XXI mentioned about 4 years ago. It spoke of a 4-year demonstration program, and now here the proposal is changed to 6 years. I sincerely hope that a title XXI will become a final fact before the end of my lifetime since I am convinced that home care is the way we all have to go for the good reasons, we in social services administration, know are valid.

Last October, the New Jersey Association——

Senator **Bradley**. Could you expand on that point, the last sentence?

Mr. **Shields**. The good reasons. I have always developed a commonsense approach to the care of the elderly and there is nothing mysterious about it. It is basic. An old lady is sick, she needs a meal; she needs a nurse; she needs transportation to the doctor; and what-have-you.

And when I hear all of the complaints that are made involving people who can't get into nursing homes, and we know it is our responsibility to take care of these people and to have them live at home in dignity, these are all good reasons that make commonsense.

So I cannot understand why we do not have proper legislation to do the things we are supposed to do for these people.

Last October, the New Jersey Association of Area Agencies on Aging cooperated with your staff, Senator Bradley, in promoting title XXI through a statewide conference that was very well attended by hundreds of concerned and frustrated home care and other professionals.

The conference committee included representatives from the area agencies, the visiting nurses, the homemakers, and the New Jersey Department of Human Services. It was not the intention of the conference to meet and commiserate with each other on our health care problems but, rather, to issue a position paper on title XXI to be used as advocacy for this kind of legislation.

With your permission, I would like to make this paper part of the official record of this hearing.

Senator **Bradley**. And I thank you. It is a part of the official record.[1]

Mr. **Shields**. We will continue to do our utmost to render the best services possible to the elderly, but we need your help so that we will not have to say, in this, the greatest country in the world: "We are sorry but we cannot give you a home-delivered meal." "We cannot send you a nurse or a homemaker because we have reached the limit on our funds." "You do not qualify for medicaid because you are not poor enough." "We cannot provide day care for your parents because there is none." "We cannot give you respite in caring for your parents because there is no such thing."

One can then wonder, is this really the greatest country in the world, especially when it comes to adequate care for our elderly?

Thank you for permitting me to testify.

Senator **Bradley**. Thank you, Mr. Shields.

Ms. Cucarro.

Ms. **Cucarro**. My name is Rosemary Cucarro. I am executive director of the Visiting Nurse and Health Services. We cover three-quarters of Union County.

Fragmentation of funding and restrictive eligibility criteria, both fiscal and programmatic, continues to be a barrier to the development of a comprehensive, integrated service delivery system.

The financial eligibility for home care under medicaid is still $500 less than it is for hospital or institutional care. Despite the growth of our aging population and the changes in their needs from acute to long-term maintenance care, the medicare program, 16 years later continues to pay for services only if skilled care is required.

Title XX pays for homemaker services and title III funds a variety of programs, one of which, fortunately in our county, is a long-term maintenance care program. Through this program, home support services are available to the disabled elderly, and nurse health maintenance clinics are available to those elderly who are not functionally disabled, but because of their chronic disease, need ongoing preventive services.

Case finding and screening, comprehensive needs assessments, case management, and service audit and program review is not the newborn of the channeling grants or the medicaid waiver. We have been doing it for over a half a century.

The Visiting Nurse and Health Services, for the past 5 years, has been working with the Union County Department of Human Resources, Division on Aging, the Union County Welfare Board, the local medicaid authorization unit and the Division of Youth and Family Services to affect a coordinated system of community care based on need.

The three other visiting nurse home health agencies in the county are also a part of this consortium. The home health agencies have been involved in need assessments for all patients receiving meals-on-wheels under title III and homemaker services through the Union County Welfare Board. That is title XX money.

Effective January 1 of this year, a need assessment and plan of care were done on all those patients receiving services from other community agencies with title XX funds. Effective May 1, 1982, a fiscal administrative unit was established at the division on aging and the titles III and XX moneys for home care are monitored by this unit.

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[1] See appendix 1, item 1, page 55.

The home health agencies provide the assessment teams, case management, and provide the service if appropriate. The administrative unit receives a copy of the screening, assessment, and plan of care, including the cost of services on a monthly basis.

Those persons requiring a service not provided by the home health agency, such as meals-on-wheels, are provided by a community agency with whom the division has a vendor agreement. But, the home health agencies provide periodic reassessments to determine continued and, or/other needs.

The system has enabled us to maximize available funds. There is no longer a duplication of services. Medicaid recipients receiving skilled or personal care services can now receive homemaker services as a part of the care plan, and that became effective July 1.

The home health agencies already have teams in place in all areas. We have traditionally collected fees, have a workable financial screening system and can collect a part fee if screening indicates ability to pay a portion of the fee.

If the patient regresses, the agency can place them on medicare until the condition stabilized, thus freeing funds to service someone else. Family and community resources are utilized. And last, but not least, the personnel have not changed.

Priorities for service have been established. We are happy to provide care to those in need, but the administrative nightmare of explaining to case managers who are nurses, who is eligible for what, and which fee source, and humanity alone demand a solution to the problem.

Title XXI must be a meshing of all entitlement moneys—titles III, XVIII, XIX, XX, with realistic fiscal and programmatic criteria covering all age groups.

I know I have run out of my time. There are some examples attached to my testimony.[1] Please assist those of us trying to meet community needs. Equalize income eligibility under the medicaid program, make title XXI a reality so we can put all our energies into caring for real people instead of trying to find a funding source to provide care.

I have addressed home care but I am acutely aware of gaps in services and the need for other alternatives in addition to home care. We, and that includes the home health agencies, must address health day care, innovative and specialized housing arrangements, and 24-hour care.

Thank you for inviting me to comment and for your attention and support.

Senator **Bradley**. Thank you. Let me ask you each just a couple of questions. Ms. Cucarro, in testimony that you gave a few months ago, back in 1980, at a conference we had, you said then that you thought that the home health agency could provide patient assessment and also be case manager. I take it from your testimony today you still feel the same way. Is that correct?

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[1] See appendix 1, item 3, page 65.

Ms. **Cucarro**. Yes; I do.

Senator **Bradley**. What programs, other than the Office of Aging programs, do you work with, or do you feel you need to work with, if the home health agency is going to provide the care in a comprehensive way?

Ms. **Cucarro**. I believe you got a letter from us asking for support. The Mental Health Association has purchased housing. They are going to house medicaid patients discharged from psychiatric institutions. They have asked us to staff it 24 hours a day.

Our problem was we already have a contract with medicaid and they could not fund a fee-for-service and a grant at the same time, and I think we wrote and asked you for support in assisting us to staff that 24-hour housing, which is going to be sheltered care and also some independent living facilities.

Senator **Bradley**. So, you are saying that you need to be able to interact more than you have in the past with housing agencies?

Ms. **Cucarro**. Yes, certainly.

Senator **Bradley**. Any other agencies—not that you have to have a long list?

Ms. **Cucarro**. Health maintenance. Definitely health maintenance clinics. We have a couple of United Way's funding health maintenance clinics for us because they do see the value of trying to keep our senior citizens as healthy as we can, for as long as we can, because it is becoming very expensive to take care of them at home.

Senator **Bradley**. So, you are saying that if the home health agency had a kind of direct relationship with an HMO in the community, that the HMO itself might find it in its interest to take a certain percent of——

Ms. **Cucarro**. It would be more interesting if medicare or medicaid could fund these kinds of HMO's, or private insurance companies.

Mr. **Shields**. We have been funding for 10 years, your health maintenance——

Ms. **Cucarro**. The Division on Aging has been funding six sites for 10 years now. And there are some very interesting assumptions you can make from the program when you look at your caseload.

Mr. **Shields**. Senator, I would like to say that I have complete sympathy for the people who are trying to give the service. The visiting nurses, when they have to be confounded by medicare and medicaid——

Senator **Bradley**. When the U.S. Senator has to be confounded by it. [Laughter.]

When I read these laws I scratched my head and said I thought the strategic arms limitation talks were complicated. [Laughter.]

Let me ask you one other question. New Jersey has had an experiment with prospective reimbursement for hospitals over the past couple of years.

The question is: Have you noticed any difference in your home health care referrals?

Ms. **Cucarro**. Certainly. The very acutely ill, some of them don't even make it home in the ambulance, Senator.

Senator **Bradley**. They don't even make it home in the ambulance?

Ms. **Cucarro**. No, they die on the way home.

Senator **Bradley**. Could you go into it a little more for the record?

Ms. **Cucarro**. We have had two patients die on the way home from the hospital in the ambulance. I am not really being very critical. I just think that everybody is very much in an economic bind and we are trying to make money if we possibly can, and we would do the same thing.

I think sometimes people are being discharged a little too early from hospitals. But here again, we are dealing with the chronically ill, fragile elderly. You take a cardiac who could be fine today and tomorrow could have a heart failure, with no indication the day before that this was happening.

And I think this is what happens between the time they are discharged from the hospital and they reach their home. We have very acutely ill patients at home. We have them on hyperalimentation. We have patients with nasogastric tubes in, patients with super public catheters in. These are all the things we can take care of at home.

So they are very acutely ill. But we also have that large case load of chronically ill patients who just need some kind of support services to maintain them at home.

Senator **Bradley**. So your point on perspective reimbursement is that the most negative thing that you see is that there is too early discharge?

Ms. **Cucarro**. I would love it if somebody would tell me what they are going to pay me at the beginning of the year and how many visits they are going to give me. I think I can do some better planning to take care of patients.

Senator **Bradley**. And let me ask Mr. Shields, I understand the work that the aging office has been doing in coordinating and I think that you have really created better use of the funds that are available.

At the same time, over the last 2 years we have had some funding cuts, and my question to you is do you think, considering those cuts, that the programs provide adequate funds for community programs?

Mr. **Shields**. Absolutely not. The funds have never been adequate.

Senator **Bradley**. Have you been able to target your programs more?

Mr. **Shields**. Oh yes. What I have done as a result of the 4.6-percent cut that we had last year, we have made some changes in Union County where instead of us now bidding out our nutrition program we do it ourselves.

In doing it ourselves now, we buy practically 50 percent of our food through the State. The State buys its food for its hospitals, jails, and what-have-you. That alone is saving us $50,000 to $60,000. We have a brand new kitchen in Union County now that is also helping us do a much better job with our home-delivered meals.

Senator **Bradley**. So are you saying that when the funding cut occurred you simply tightened up; you did not serve fewer people?

Mr. **Shields**. I had been planning this change for about 4 or 5 years. It was just coincidental that it happened when the funding cut came. If the funding remains the same next year, and there is an inflation, then I am going to be hurting next year.

Senator **Bradley**. So you were wise several years ago to look ahead.

Mr. **Shields**. A little bit that way. But, as I say, it is all commonsense in watching your dollars. But I am not at all satisfied with our home-delivered situation, even though I think we have one of the best in the State. I am not at all satisfied when I have to say to the visiting nurses we just don't have sufficient funds for you to provide the number of visits that you are supposed to or should.

Senator **Bradley**. Let me thank both of you for your testimony. It is always helpful and reassuring to hear New Jerseyites who are out there on the line doing the job, and I think you have been very helpful in your comments.

Thank you very much.

Mr. **Shields**. Thank you so much.

Ms. **Cucarro**. Thank you.

Senator **Bradley**. Next we have the hospital perspective. From Burlington County we have David P. Hunter, president, Burlington County Memorial Hospital, and William J. Kane, vice president for medical affairs, Burlington County Memorial Hospital.

Gentlemen, welcome to the committee, and I ask you to proceed.

PANEL NO. 3

STATEMENTS OF DAVID P. HUNTER, PRESIDENT, AND WILLIAM J. KANE, VICE PRESIDENT FOR MEDICAL AFFAIRS, BURLINGTON COUNTY, N.J., MEMORIAL HOSPITAL

Mr. **Hunter**. Thank you, Senator Bradley. My name is David P. Hunter, and I am president of Burlington County Memorial Hospital, and I have with me today, William J. Kane, who is the vice president for medical affairs.

Burlington County Memorial Hospital, for the committee's information, is a 688-bed, vertically integrated hospital and health services system in southern New Jersey serving parts of southern Ocean County and parts of Burlington County.

We operate two hospitals, one of 100 beds in Manahawkin, N.J.; we operate a 360-bed hospital in Mount Holly; a 120-bed nursing home in Mount Holly; and a 68-bed nursing home in Moorestown, N.J.

I want to start by applauding the comments that we heard earlier. As you will hear from our testimony, those elements of the health care system for the elderly are absolutely essential, and from our view, in critically short supply as we go toward trying to meet the needs of the elderly population in the next decade.

We would also probably comment on title XXI, saying that while it is an excellent attempt to integrate heretofore fragmented health services, it may not go far enough in influencing the acute care and nursing home sectors to participate to their fullest responsibility in the care of the aging population.

The aging population is a reality. Our hospital became very concerned about it when we discovered that 65 percent of the admissions to one hospital were medicare patients and 45 percent of the admissions to another were medicare patients.

We further concluded—it doesn't take much of a crystal ball to see that—that if you look at medicare it can be no surprise to anybody that the Federal Government cannot afford to take care of all of the elderly patient if it is going to be faced with using the acute care sector alone. It is just going to be financially impossible for us to stretch that far as a country and provide that kind of care in hospitals.

Those thoughts led us to consider expanding our horizons and to try to get into some additional services that would provide a coordinated system to take care of the elderly patient. We believe that existing health resources, especially hospitals and nursing homes, need to be influenced by the Government and others to develop coordinated and efficient low-cost delivery systems, particularly as it concerns the elderly population, who will shortly be the biggest users of our Nation's health services, if not now.

At BCMH, we are looking at a four-part system of health care that we like to think is somewhat vertically integrated. We are looking at outpatient ambulatory services, including geriatric assessment. We are looking at inpatient acute units for the frail elderly. I am not talking about the generally admitted healthy medicare patient, I am talking about people with multiple problems who need a special environment when they are in the hospital.

As I am sure you are aware, hospitals can be one of the most traumatic and potentially damaging institutions for our elderly in the country if we don't learn how to take care of them better.

Then we have concluded that it is essential for hospitals, in this day and age, to involve themselves in the long-term aspects of care through nursing homes. It is clearly not enough to stop at the nursing home level of care. We must begin to be influenced, urged, and become interested ourselves in participating with the people who you have heard from earlier today, in developing those coordinated systems that place people beyond the nursing home in the community, in a variety of settings, at the earliest possible time after their hospitalization.

We heard the lady testify relative to the early discharges, and I think that is an appalling set of circumstances. Hospitals need to take a responsible role in making sure that the place that they go is the appropriate place for the care of that patient, and we need to work with the community agencies to achieve that.

Reiterating the reasoning behind our involvement in the care of the aging to the extent that we are trying to commit ourselves currently, the increasing aging population is, of course, a critical one. The opportunity to develop the fourtiered system of outpatient, acute inpatient, nusing home, and then other kinds of agency care is also a very important reason we feel we need to be in the business of caring for these people in a more organized way than we have.

And then, last, and probably as important, as you look at the whole health system in the United States, the response to perspective reimbursement in the acute setting is going to act, as was testified to earlier, to move patients out of the acute setting more rapidly into other levels of care.

Our concern and our reason for getting into nursing home care, is we don't believe that the nursing homes in the United States are necessarily prepared, nor are the agencies necessarily prepared, for the influx of acutely ill patients who will be moved out earlier from their hospital care as a result of the perspective reimbursement systems currently operating in New Jersey and proposed nationally.

We think it is important for hospitals to cooperate with these agencies and to develop ways of making sure that those people are in the most appropriate level of care and most well cared for.

We think that the Federal Government, through legislation such as you proposed, through some additional thinking relative to this particular problem, may well be able to affect that within the resources that we are already using. And I am talking specifically of attempts to deregulate the way in which we move patients between nursing homes, hospitals, and levels of care described by others earlier.

Right now it is very hard for us to move patients around this system, and you almost need a passport to get from one level of it to another, and we really need to break down some of those barriers, and make it easier through some sort of attempt to deregulate between the segments of providers for the elderly population in the country.

And last, it will not be enough simply to develop prospective rating or prospective reimbursement for hospitals. What we need to be able to do is to develop prospective reimbursement at the nursing home levels as well, to provide a real incentive for nursing homes to get in the business of offering rehabilitative services, occupational therapy, social services, physical therapy, and medical care similar to the story you heard about the drugs earlier, to try and get these people out of the nursing home, to that more appropriate level of care which we believe is the most reasonable, as well as the people who you have heard from earlier.

With that, I will conclude my comments and thank you and turn it over to Dr. Kane.

Senator **Bradley**. Thank you, Mr. Hunter.

Dr. **Kane**. My name is Terry Kane and, as Mr. Hunter said, I am the vice president of medical affairs for Burlington County Memorial. I am also the medical director for Burlington Geriatric Centers, which is our corporate affiliate to manage our nursing homes.

As David said, we are trying to develop a comprehensive system and my comments today will be aimed at what I think is part of the missing link, the role of the physician and the link of title XXI and other programs to the existing medical channels. I think it is interesting that many of the comments earlier today alluded to the problems linked to existing medical channels.

I might also say, I wonder how many physicians are in the audience behind me, as compared to other professionals working in the field of aging.

Although inadequate reimbursement is often suggested as a reason for the current absence of an organized system of long-term care, it is my impression that the medical profession's failure to conceptualize the framework for progressive health delivery to the aging, even to know what good geriatric care is, is just as or perhaps more important.

In designing a health care system for the elderly I think you have to remember that they are not a homegeneous population. Some are frail, some are less frail, some are very fit. There is the same diversity in the families who look after them and, as a result, I think that the needy and their families often compete with the less needy and it becomes an issue of survival of the fittest.

I therefore agree strongly with the idea of the assessment in the community and trying to make a better use of resources. I think that basically though, again, as Mr. Hunter has said, I am concerned that the legislation doesn't go far enough.

I think that becomes clear when you look at the effort that is expended to identify high-risk elderly in an attempt to prevent institutionalization. And it is often difficult in my experience, to identify and intervene with those elderly at risk, because the major precipitating factor is nearly always acute illness or injury and the secondary effects of that illness or injury on function.

The time of onset of the illness to admission is short and any intervention procedures would have to be very rapid and linked to existing medical channels, particularly the acute hospital. This is currently not the case. As a result, I think many preventive and health maintenance activities are missing the high-risk elderly because I submit that the most high-risk elderly are those that are currently in the hospital.

In our acute hospitals, functional problems of the elderly are not improved. They actually deteriorate rapidly after very short periods of hospitalization and in actual fact, one of the biggest stresses on home care and the care in the community is that the hospitals and physicians, in general, do such a poor job of maintaining function. The patient never, in my experience, or very rarely ever returns from the hospital to the community needing the same level of services that they needed before they entered the hospital.

I think that the analogy——

Senator **Bradley**. Could you go into that in a little more depth?

Dr. **Kane**. If you take a lady that was functioning extremely well at home and happened to fall and break her hip, by the time she gets into the hospital, becomes acutely confused by the relocation into the hospital, anesthesia, surgery, the trauma, when she is not handled by professionals in the hospital who understand elderly, and that includes nursing and physicians, she often comes out of the hospital with continence, bed sores, increased confusion, depression, and many other things which result in a much lower level of function than before she went into the hospital.

If the system in the hospital were better and perhaps linked to a very aggressive rehab situation in our nursing homes, far more of these people would be returned home.

I would make the analogy, Senator, that hospitals learned a long time ago that you never nurse children or psychiatric patients on the same unit with other patients, and you should not nurse 85-year-old patients on the same floor with 40-year-old patients.

I would say that our system at Burlington County Memorial Hospital takes into account the first parts of your bill which are community-based assessment units, and I would make a particular plea that those prioritization procedures, especially for institutionalization be equalized between those waiting in the community and those in the hospitals. I think hospitals are getting the priority now.

There should be coordinated and comprehensive community services. What I am suggesting is that we go a lot further than that and that we look at a substantive change in the way that the frail elderly are handled in our acute hospitals and that we look at changing our nursing homes to provide better rehabilitation for the patient with high potential to return home.

We in Burlington County right now, with our 188 long-term care beds, have a difficult task influencing the quality of medical care delivered in our nursing homes. It is that same thing that I opened with, the failure to appreciate what good care is, and to identify those patients with a real potential to return home. And I can give you numerous instances of that, beginning with cases that I saw this morning.

Finally, in the 1970's, when there was a real primary care problem in the United States, there was a tremendous Federal initiative to look at the types of physicians being produced by our medical schools, and that initiative was by anybody's standards, extremely successful in increasing the availability of family physicians and general internists in the United States.

I think that because of our current economic situation, there is no Federal initiative currently to insure that medical schools in this country include geriatric medicine in their curriculum. My assertion is that unless you do that, and unless you produce some physicians skilled in geriatric care and give them an incentive to care for our elderly, that you can do everything that we've talked about earlier today and you will not link services to existing channel and it will be far less effective than it would be otherwise.

I think that medical education is very clearly essential in any attempt to link long-term care with the existing medical channels. With that, I will stop and will be glad to answer any questions.

Senator BRADLEY. Let me follow up on that last point. You say physicians aren't educated today to know how to use long-term services. You mentioned that we should provide them with some incentives that would get them to refer those patients to community long-term care. What kind of incentives would do that?

Dr. KANE. I want to step back because I am not interested in just the referral. I think that there seems to be a misconception in many people's minds that many of the problems which elderly have are not medical in nature and therefore, they need more social services than they do medical services, and that is indeed true.

The problem that I have is that the physician who misses the accurate medical assessment often misses reversible conditions which then place an extra burden on the social services. So I'm not only interested in the——

Senator BRADLEY. You mean he misses seeing something that can be corrected?

Dr. KANE. That is correct.

Senator BRADLEY. And instead of correcting it, because he doesn't diagnose it properly, he simply passes it on to another acute care level?

Dr. Kane. Or we pass it on to our long-term care system to take care of. I will give you an example. If you miss Parkinson's Disease in a 75-year-old, which is a very treatable condition, certainly for a number of years, and can make all the difference in the world with whether somebody can care for themselves at home or whether they have to go to a nursing home, if that diagnosis is made incorrectly, or it is treated incorrectly—and it can be a very difficult thing to treat in older people—then you place that person—you automatically condemn that person to a level of care far above what they would need if their medical problem was taken care of properly.

And there are numerous examples where lack of specific medical knowledge of the care of the aged population results in much more disability and loss of function than is reasonable.

So, it is not only the referral. It really comes down to assessment—and I would ask the people who testified earlier where they go to get medical assessment, and if it is similar to Burlington County you will find that very few places have available that type of physician who really spends greater than 50 or 60 percent of his professional time taking care of older folks and is competent in geriatric care.

Senator Bradley. So, are you saying that the problem is with the medical schools themselves, they don't train people in geriatric medicine? I mean, if you look at demographics you see that in the next 20 or 30 years that's going to be a booming business out there. Why wouldn't people want to get the skills that would make them the best geriatric doctor that they can be?

Dr. Kane. One of the problems today, Senator, is there are very few people in the medical schools who could teach this, very few. And if you don't have a cadre of physicians to teach, the next generation comes out without the skills.

And I think the other problem that you have, in all honesty, and it sounds simple to say, but physicians are able to judge each other's quality of care in the hospital and with other populations very clearly. There are clear-cut standards for what good care and what bad care is.

Right now in the United States there are no standards for what good medical care is for old people, and very few physicians would be able to tell you what good care is.

Senator Bradley. Could you give me an example? Like, where are there clear standards for care and how there are no clear standards for care with the elderly?

Dr. Kane. It is a difference in how you look at a patient, and in the elderly, the bottom line is function. You have to make that person function, and that is a different philosophy than the average physician has with younger patients.

I can give you an example from this morning. I was asked by the physical therapist in one of our nursing homes to take a look at a lady who was not doing well after a stroke. The physician had not performed a comprehensive review. The fact was that the lady was markedly anemic following hospitalization, and nobody paid any attention to that, and it also followed up that the patient is markedly depressed.

Now, failure of the physician to put all of that together and to work with the nursing staff, the physical therapist, and the rest of the people in the nursing home, has condemned that lady to being in that nursing home forever.

Senator **Bradley**. I think you make a very interesting point. I think a very important point. Let me ask another question. Do you think by having nursing homes owned by a hospital that you can change the way a medical staff cares for the elderly? Are they more likely to discharge people from the hospital to a nursing home; are they more or less likely to take someone out of a home-care setting and put them in a nursing home?

You can both answer that if you want.

Dr. **Kane**. I could comment. One of the things we are doing is obviously using our nursing homes in this long-range plan to get into medical education. We have a new family practice residency program which clearly advertises for applicants who are interested in taking care of elderly. They are the students we are interested in attracting.

In our nursing homes right now, Senator, my biggest frustration is that I don't have a group of physicians that I really think are taking very good care of the elderly.

Senator **Bradley**. Let me ask you, how did you learn how to take care of an older population?

Dr. **Kane**. I formerly was chief of the division of family medicine at Duke University and, to be honest with you, I spent 1 year with a visiting Scottish geriatrician, and I learned very quickly that I knew nothing about taking care of the elderly and that he knew a lot.

Following that, I did a lot of reading on my own and subsequently I became the medical director of a very large life care community in New Jersey, I took care of 400 80-year-olds day in and day out for an entire year.

Senator **Bradley**. So, the way you've learned is that you started by accepting what you didn't know and then you built back up.

Dr. **Kane**. But I had a faculty role model and you can't underestimate that.

Mr. **Hunter**. Senator Bradley, just sort of an expansion on that comment relative to how we think we can influence the medical care in nursing homes; when we got in the business it became clear that a lot of what Terry has had to say was true.

The fact of the matter is that hospitals, using some of their resources, should be able to provide for direct relationships with physicians to provide primary and other care for patients in nursing homes. We can make it a little bit more interesting and a little bit more reasonable to get those physicians in the nursing home because we have some control over them.

Senator **Bradley**. Would you excuse me? I would like to recess for 2 minutes. I have a couple of Senators that I have called on a vote that has to take place tomorrow morning. It is for New Jersey, and I want to make sure that they are going to vote with us. Would you excuse me? One is on the phone.

We will break just for 2 minutes.

[A brief recess was taken.]

Senator **Bradley**. The committee will come to order. Could everyone please take their seats. I am sorry for the interruption but, unfortunately, there is no phone here.

You were saying, Mr. Hunter.

Mr. **Hunter**. I was just trying to make the point that when a hospital buys a nursing home we rapidly conclude that there is an institutional responsibility to see that the medical care is provided, and we have some other ways at our disposal of doing that.

For example, the hiring—the direct hiring of physicians to provide that care within the nursing home setting. It is very hard to attract physicians to a nursing home when it stands out all by itself. The reimbursement is bad. They are not encouraged to come in for a variety of reasons. It is very hard to get clinical participation by doctors in nursing homes unless the physician happens to be personally committed, and it relates to a whole variety of reasons.

When a hospital becomes involved with them and it is a part of our responsibility we, unlike the nursing homes, very often have other ways of influencing the physicians to participate in the nursing home care; hiring them; direct payments for them; making it part of the rules and regulations of our medical staffs; those kinds of things.

Senator **Bradley**. Let me ask you this: How does a hospital gain the cooperation of its physicians when they both admit and discharge a patient and for whom it might be, frankly, easier and more lucrative for them to keep the patient in the hospital?

Mr. **Hunter**. The answer to that in New Jersey is that currently under our reimbursement system we are encouraged, as you know, to discharge at the earliest possible time from the point of view of the patients.

Physicians in our hospital have been educated over the course of the 3 years of the existence of the DRG program as to the importance of early enough discharge from the hospital and to seek proper placement in other levels of care.

Senator **Bradley**. So that you say from your perspective you have been able to use prospective reimbursement as essentially the tool by which you have educated the physicians that it is in their interest to discharge at the earliest possible time.

Mr. **Hunter**. Senator Bradley, in the last 2 years we have cut 1 day per year off our average length of stay, dropping it from, I believe, in the high 8's down to the high 6's. And that, I think, has a lot to do with the curtent reimbursement environment.

Dr. **Kane**. I do not believe that utilization review in the hospitals, despite what might be some isolated examples, is penalizing some people. There may be people going out of the hospital sooner that might need more services, but I think during those 6.8 days in the hospital the condition of the patient on discharge is very dependent on what was done to the patient during those 6.8 days. I think utilization review is absolutely essential to insure better use of the days in the hospital.

I could get into some of the links between the hospitals and nursing homes and how patients are ping-ponged back and forth at tremendous cost because we don't have adequate services in nursing homes. If you really wanted to get into saving money I will give you an example.

In the nursing homes we just took over they have never debreeded an ulcer or cleaned it up. They don't have any instruments whatsoever to do that. They have transferred every elderly patient needing any kind of suturing or surgical procedure, however minor, at medicare or family expense to the surgeon's office or to the emergency room.

Because of no incentive in reimbursement we did not own an EKG machine in either nursing home. Patients needing an electrocardiogram were transferred, again at great expense. The issue comes back again to what is reasonable care, and you can—I guess when Dave talks about deregulation there is a lot of adverse publicity to deregulating nursing homes—but I would have to say that the paper process that is going on now has no relationship to quality care.

Senator **Bradley**. So what you are saying is if we really set up a long-term system it would lead toward some deregulation and toward the situation that you described, where hospitals have an interest in nursing homes. Hospitals can assure that if it is a minor problem in a nursing home, you have the staff to address the minor problem rather than pushing it back to the acute care hospital facility. And you are saying that it is your hunch that this would be less costly.

If you can back that up with any data, it would be very helpful to all of us who are trying to argue the long-term care position in a very austere fiscal mood.

Dr. **Kane**. I think the long-term care model though, when you start talking about coordination, must include the nursing homes and the acute hospital, and it must include the skills of the physicians who control care in those settings.

We just took over the nursing homes May 1, but we are working very hard to set up a demonstration project and an acute hospital unit to answer the questions which you are asking—can we, in fact, discharge elderly sooner, in better shape, fewer of them going to nursing homes, that type of data.

Funding should be available for demonstrations. I think there should be some incentive to acute hospitals to begin to look at such data. We are not very well equipped. We are not like a university. We don't have a lot of statisticians and people like Dr. Rabin around who can set those studies up for us.

We need some outside incentive and support.

Senator **Bradley**. Do you think physicians should receive a set fee per diagnosis, or per patient, or do you think government should pay per service?

Dr. **Kane**. Let me comment on that indirectly. I think what currently goes on in nursing homes, having everyone seen every 30 or 60 days, is a waste of money because the patient may not need to be seen, and the physician may have few, if any skills in geriatric care.

I think, what happens right now is not much service is provided, and it is simply a visit to fill out a piece of paper and sign your name.

Senator **Bradley**. So you think that basically the patients don't get the care? It is just a way to collect fees?

Dr. **Kane**. In many cases, Senator, the patient doesn't need that physician care and then, even when they need the physician care, I think that the quality of it, and the insight, is not always there.

I think, that my own bias of nursing home care—and I know many of my physician colleagues would not agree with that—I think, all nursing homes should limit their medical staffs to the number of physicians who are fairly knowledgeable and committed to the nursing home, and should have then a major role in the development with the nursing staff and the other health professionals of a philosophy of care.

I don't believe that the current situation where a nursing home has 20, 30, or 40 separate physicians coming in item-for-item for service—in that respect I think, that the home might have *x* amount of dollars to provide total medical care on a capitation basis and I would like to experiment with that.

Senator **Bradley**. If you move into that level, say, of deregulation, what is your answer to the question: how do you prevent the abuses?

Dr. **Kane**. I would not move into that level of deregulation without some demonstration project to answer questions.

Senator **Bradley**. Going too fast?

Dr. **Kane**. Well, if you examine the literature, we have very little proof that providing the kinds of services we are talking about are cheaper. There are cases in Europe where sheltered care has proved to be more expensive than nursing home care, and where day care has proved to be more expensive and less——

Senator **Bradley**. Let's assume that title XXI passed next week and it was law and one of the demonstrations was going to be in New Jersey, maybe even in Burlington County. What questions would you want that demonstration to answer?

Dr. **Kane**. I would want that demonstration linked to the hospital and the nursing home to begin with. I would like to compare a controlled group of patients in the hospital being given *x* amount of services in a special unit versus patients who were not. Is there a difference in time of discharge, function at discharge, and number sent home versus to a nursing home?

There are a number of other parameters that you could measure in the hospital with that population. I think, you could then look at the nursing homes to decide how many of those people you got back into the community and that could be measured.

Mr. **Hunter**. One of the keys, Senator, in that kind of an observation, if you want to make it at all useful in terms of long-term policy decisions would have to be can we, through providing a number level of coordinated services from the acute setting to nursing homes linked either by contract or direct provision of services to home care, day care, medical day care kinds of providers, can we return the person to function faster, and can we do it for as much as or less cost than a hospital who is not engaging in such a system.

I think, that would be a critical question for you to answer in terms of whether or not the system ought to be modified in the future. And that is the kind of a question that you asked us, and

Terry answered by saying the resources to do that in the community hospital setting today, as you know, are not real popular from a cost point of view, and that is one of the critical absences in terms of being able to look at the question you posed.

Senator **Bradley**. If you were able to discharge patients to nursing homes or to home health care programs earlier, do you have any sense of what you would save in hospital days?

Mr. **Hunter**. I think, that there is no question that there is a bottom to the number of days that you can shave off the hospital stay. If the nursing home provided the services that Terry talked to earlier, that is, good, dependable medical care, some services that are a little more advanced than you would find in the average nursing home, good PT, good OT, and those kinds of services, I believe that we could probably, in the elderly population anyway, shave at least another patient day off of our stay, which is extremely expensive.

There would be some offsetting additional expense at the nursing home as we increased the level of service provided there. The net effect ought to be a heck of a lot less expensive than it is to provide a day of hospital care today. And, as you know, it is exorbitant and we are all concerned about that.

Senator **Bradley**. One of the issues that we confront with the nursing homes generally is the source of payment problem and the mix between private and public payments. I am curious. In your nursing homes are you having a mix of patients, and how have you decided to set that mix?

Mr. **Hunter**. Again, in response to the way the regulatory requirements works, we have set it arbitrarily, and we have set it at a balance point to try to provide for the financial viability of the nursing homes. Obviously we can't run them at a loss. Our philosophy is to run it break even or slightly better than break even as a financial management philosophy.

Right now, 30 to 35 percent of the patients in our nursing homes are on medicaid with the remainder of the patients being made up of medicare, a small amount of medicare, self-insurance, and largely private pay. I would suggest that the amount of money being paid by the private paid patient—as you know we still operate nursing homes on the tried and tested method of Robin Hood reimbursement, and unfortunately——

Senator **Bradley**. What is Robin Hood reimbursement?

Mr. **Hunter**. Robin Hood reimbursement is essentially subsidizing the poorer patient off of a more well-off patient, and that is largely the way we operate. To affect that balance you have to have more people in the private pay category to be able to pick up the potential medicaid loss.

Senator **Bradley**. I have a number of other questions. Maybe what I could do is just submit them to you and could you perhaps provide some written answers because I think that it would be extremely helpful for the record to have your experience reflected and we are up against that time. Even with my break we are about 15 minutes over.

Mr. **Hunter**. We would be pleased to.

Senator **Bradley**. Thank you very much.

Our next witness is from Harvard Medical School, Dr. Laurence Branch, who is an assistant professor there. And he is from Home Care Corporations in Massachusetts.

Dr. Branch, welcome to the committee's hearing and proceed with your statement.

STATEMENT OF LAURENCE G. BRANCH, PH. D., ASSISTANT PROFESSOR, HARVARD MEDICAL SCHOOL, BOSTON, MASS.

Dr. **Branch**. Thank you, Senator, it is nice to be here.

I would like to take this opportunity to discuss Senate bill 861, The Noninstitutional Acute and Long-term Care Services for the Elderly and Disabled Act. My comments are based on nearly 10 years of policy research experience, the last several of which have been as a faculty member of Harvard Medical School and Harvard School of Public Health, and a member of the executive committee of Harvard's Division on Aging. In addition I am a member of the Boston VA's Geriatric Research Education Clinical Center.

My comments on the proposed act will draw heavily on my experiences with the Massachusetts Home Care Corp. network. During this discussion of a proposal policy alternative, I will return repeatedly to four basic policy issues: (1) Who sets something? (2) What do they get? (3) Who pays for it? (4) Who monitors its quality?

In 1973 the Commonwealth of Massachusetts became the first State to establish a cabinet level department of elder affairs, and charged it with establishing a home care program.

The State was divided into 27 planning and service areas and the first two home care corporations were established in 1973, with all 27 areas covered by July 1, 1977.

The Massachusetts model of home care is based upon six basic elements:

One, destigmatization. Prior to 1973, services to elders in Massachusetts were provided through the department of public welfare under the old age assistance program. The first element of the Massachusetts home care concept, therefore, is to destigmatize the receipt of service by removing it from the welfare model, thus opeing up the possibility for more people to apply for services that they need.

Two, local consumer input. This concept includes the element of local decisionmaking and directly involves elders in policymaking. Underlying this concept is the assumption that a truly responsive home care program must take into consideration local needs and the perspective of older persons.

Three, minimization of redtape. The program seeks to avoid the well-known problems of bureaucratic redtape, including civil service, State purchasing requirements, and so forth, in the interest of facilitating the provision of services to the elderly.

Four, case management. The primary target group of the home care program is those elders with a combination of needs, the solution to which requires a multiplicity of services, frequently from many agencies. The process of traveling through this labyrinth of agencies has been appropriately called the referral runaround, where a person is sent from one agency to the next trying to put together his or her own package of services. As Spencer (1974) found, for clients with more than one need the probability of setting the first needed service is 40 percent; the probability of effective referral to a second service drops to 17 percent. To overcome this runaround, case management is a key element in the Massachusetts home care model. An older person's needs are assessed in one place and a package of services, complete with all the funding arrangements, is put together on behalf of the older person.

Five, multifunding. Funds for services to the elderly come from a variety of sources, including title XX, title III of the Older Americans Act, title XIX, and so forth. In the Massachusetts program, a vehicle is available to utilize these funding sources on behalf of the older person.

Six, priority to the elder. The fact that some service agencies discriminate against elders is known, as has been documented recently by the U.S. Civil Rights Commission—U.S. Commission on Civil Rights, 1977. An agency uniquely designed for elders, thereofre, is considered necessary.

Given these underlying elements of destigmatization, local/consumer input, avoidence of redtape, case management, multiple funding, and non-age-discrimination, the Massachusetts model of home care emerged as 27 nonprofit corporations located in each planning and service area in the State. Each corporation is controlled by elders with a board of directors, 51 percent of whom are from local councils on aging. These corporations are the exclusive agent of the department of elder affairs charged with the delivery of social services available through the department. The program's core services include information and referral, case management, and homemaker, chore, and transportation services.

The corporation hires its own staff, including its case managers, and contracts with other local providers such as homemaker agencies, transportation companies, and so forth, for the delivery of services. The organization monitors the delivery of those services and works to provide high quality care. In addition to destigmatizing services, creating private, nonprofit home care corporations would hopefully facilitate adaptations to local needs, encourage local financial support and participation, and avoid the inefficiencies of large scale, centralized bureaucracies.

By early 1979, the home care corporation network had been fully operational for over 1½ years. The number of clients being served rose from 10,000 under a partial system in 1974 to an estimated 33,000 for 1980. The total expenditures for those same years were $4.6 and $45 million respectively. The department of elder affairs concluded the system had expanded sufficiently to warrant an evaluation to determine the extent to which this approach to delivering home care sevices was reaching those in greatest need. In particular, the department wanted to identify the characteristics of those being served by the program; establish a baseline of client characteristics against which change, over time, could be measured; and identify potential problem areas and/or matter for further study.

To evaluate the degree to which the home care corporations were successfully targeting services to the vulnerable elders, the department of elder affairs decided to compare the demographic characteristics of a representative sample of home care corporation recipients with the background characteristics of vulnerable elders in the Commonwealth. The department had been using data from one of my earlier studies to define the vulnerable elders in the Commonwealth—Branch and Fowler, 1975; Branch, 1977. This evaluation was undertaken in part to identify the characteristics of those initially served as a means of identifying those in need yet unserved. Such a description would help tailor future efforts toward client solicitation and targeting. Such information may also be instructive to those considering similar endeavors around the Nation.

What can be learned from the evaluation of the Massachusetts model of delivering home care services to elders?

First, the data clearly indicate that this statewide system developed under nonprofit auspices has been very successful in providing access to older persons and in reaching its target population—the vulnerable elders. The demographic composition of the home care corporation sample is generally very similar to the group that the services are targeted for, the statewide subsample who meet Branch's definition of vulnerability. Home care services are reaching those elders in the community with the greatest need for the services. This successful targeting of home care services has occurred in an environment of decentralized management, minimum regulation, and minimum central control. Such success probably would not have occurred under a system that carried the stigma of welfare or without the active participation of consumers in designing and operating the system. The active involvement of elders on the home care corporation board of directors has been an instrumental component of this success. Some elderly board members participated in the service programs as recipients providing immediate feedback on the services. Many elderly board members were instrumental in establishing home care corporation credibility with local government and community groups. Many of these elders became vocal advocates for elder rights mobilizing other elders, writing letters, and visiting elected officials on behalf of the elderly.

The home care corporation recipients do differ in some respects from the statewide sample of vulnerable elders; the pattern of these differences, however, is encouraging. The home care corporations appear to be reaching the subgroup of vulnerable elders less likely to have viable informal networks of support—those living alone and the widowed. Thus, these data suggest that the home care corporations are not supplanting informal support sources traditionally used by elders for assistance in many of the kinds of activities offered by the home care corporations. Those in need, but without informal support, are being attracted to the home care corporations. Although this is encouraging from a narrow targeting perspective, it may reflect a bias against assisting families whose caretaking responsibilities are severe. Whether this might contribute to the breakdown of family support is an area for further study.

A second major conclusion is that data indicate there are many older persons living in the community who are vulnerable and who need and can appropriately utilize home care services when they are available. The demand for this type of social service exists, but the demand is neither excessive nor uncontrollable. Approximately 3 percent of the elderly population in Massachusetts were served by the home care system at that time. The total target group was approximately 5 percent. The Massachusetts experience indicates that the older consumer is indeed capable of appropriately utilizing these services when provided through a social service home care model. This supports the use of a more comprehensive model of home care instead of an exclusively medical model which bases access to home care services on medical judgment in an attempt to limit demand for these services. The Massachusetts experience should lay to rest some of the fear of policymakers about expanding services from demonstrations to statewide programs.

Third, a support program should be flexible to meet the needs of clients. This flexibility can be greater when a competent professional is allowed to develop a care plan based on client needs rather than a service package based on authorized services. The temptation to overspecify in the enabling legislation and subsequent regulations is strong indeed; please try to resist. I am sure all of us can draw on personal examples in which an organization needlessly created "Catch 22"-type situations. I am reminded of government travel regulations. Sometimes there excessive specification of how to achieve the most cost-efficient travel in general precludes the most cost-efficient travel in a particular instance. The point is that we know the limitations of the approach which specifies the means—specific service authorization—rather than emphasizing the goal—solving client problems. Let us not limit our potential achievements by following the same path in the "Noninstitutional Acute and Long-term Care Services for the Elderly and Disabled Act."

Six specific services are proposed in the act in the "Scope of Benefits" section, and a seventh which the Secretary of Health and Human Services might determine to be of value at a later point. I respectfully submit that the Secretary probably will not ever have to develop a plan of assistance for a client in need, but the Secretary will have discretionary power. The case managers who will have to develop many case plans do not at present have discretionary powers. Please give them some. It is not as if case managers have abused this kind of discretionary authority in the past. Let us not lose sight of the fact that individuals will have problems, and that services are means of solving the problems. But the process of determining the best means in a given situation requires a competent clinical judgment. Give the clinical case managers some discretional power.

Fourth and last, the Massachusetts experience do not tell us much about a complete merger of titles XVIII, XIX, and XX programs; that is, a complete mix of the medical and social support programs. The Massachusetts home care program is primarily a coordinated social service program with some limited control and responsibility for some titles XVIII and XIX services. It has not been a fully integrated medical and social service home care program, with the exception of its new channeling demonstration project. Though the preliminary evidence is encouraging that the medical and social support programs can be coordinated, more experience is needed.

In summary, then, we have demonstrated that home care services can be coordinated, can be targeted, and can be fairly cost-efficient. We provided needed services. However, we are not certain whether or not we delayed institutionalization, which I think is going to be a critical point for our demonstration project and for your title XXI proposal.

The research projects that exist today tend to demonstrate that the home care programs provide a needed additional service but, as yet, they are not an alternative to institutional long-term care. They are needed in their own right because we have gaps in services; but at the moment there is no substitution.

Senator **Bradley**. You mean that if you expand home health care you will be touching a population that is presently not in nursing homes?

Dr. **Branch**. Yes, Senator, a population that is currently underserved.

Senator **Bradley**. How does that then coincide or fail to coincide with the statistic that we often hear that 40 percent of the people in acute care hospital beds don't need to be in acute care beds, and also that many people in nursing homes don't need to be in nursing homes?

Dr. **Branch**. I think the figures come from different perspectives and the latter one comes from a different time. I think the issue of administratively necessary days, as they are sometimes called in some places, is very complicated, and if one looks at the data critically, one finds that those who are able to pay for long-term care out of pocket do not have the same backup in acute care facilities as those patients who are awaiting placement in nursing homes who are going to be public pay patients.

That seems to suggest that the payment mechanism has something to do with the use of administratively necessary days.

Senator **Bradley**. You lost me. Say that again.

Dr. **Branch**. Patients who are awaiting placement for care and are going to pay for their long-term care out of pocket have fewer days awaiting placement than a comparable functional status patient whose payment mechanism in long-term care is going to be——

Senator **Bradley** [interrupting]. Reimbursed by medicaid.

Dr. **Branch** [continuing]. And in addition, there was a very thorough study initiated several years ago in Manitoba because they were facing the same problem of a considerable amount of geriatric patients "backed up" in acute care hospitals. They established more institutional beds and more home-based support services with the assumption that this is going to solve that problem.

They waited 5 years for all of the facts and figures to unfold and at the end of that time, the use of administratively necessary day patterns did not change. So, something more complicated is going on. I think the problems associated with extensive use of administratively necessary days in acute hospitals will not be solved either by more home-based care or more long-term care beds.

Senator **Bradley**. Are you saying that it is your hunch that if we expand home care, simply more people will use home care who are presently not using anything?

Dr. **Branch**. Yes, sir, but I do not say that with apology. I think that our program of support services to elders has been deficient in the past. There are more people who have a legitimate claim on support services than we have provided in the past.

The fact that we might be discussing expanding services for them as a means of reducing overall cost is all right. I might prefer discussing expanding home care services as a means of expanding the continuum of support available to elders, but we can share the same method for different goals.

Senator **Bradley**. But if 80 percent of the elderly's long-term care needs are met by family members, in a noninstitutional setting, then we are really talking about 20 percent of the elderly population. It is your view that that is the segment that is underserved, or are you asserting that the 80 percent that are presently with families or friends are underserved?

Dr. **Branch**. Though some of the 80 percent currently receiving their support from families might be underserved, I think we can assume that most are adequately served. Concerning the other group though, our experience in Massachusetts showed that the demand for these public community-based support services was about 5 to 6 percent of the population, not the other 20 percent. Though this 5 to 6 percent rate of demand is constrained by income eligibility factors and the like, the presumption at the moment is that—if there were a full service supply available—the demand for these kinds of community-based services probably would not exceed 10 percent of the total noninstitutionalized population. That is, the magnitude of the service program that we would expect, based on our experiences, with some variation depending on sliding fee scales and reimbursement policies.

Senator **Bradley**. So you are asserting that, say, 10 percent of the elderly today—32 million in the year 2000 and it is now 24 million—so you are saying roughly 2½ million is your target population today?

Dr. **Branch**. Yes, sir.

Senator **Bradley**. And are you saying, based upon your demonstration, 2½ million times $1,300 is your budget?

Dr. **Branch**. That would be a reasonable starting point in 1980 budget dollars.

Senator **Bradley**. I am sorry, I didn't mean to interrupt you.

Dr. **Branch**. It is quite all right.

Thus far, I have tried to emphasize two of the lessons to be learned from the Massachusetts experience. First, that coordinated, target home-based services can be provided in a cost-efficient manner. Second, that the demand is not excessive by some perspectives, that perhaps 5 to 10 percent of the population will avail themselves in this kind of home-based support services.

Such home-based public support services do not have to be in competition with the informal support already provided. In Massachusetts, over 70 percent of the recipients were living alone and presumably had no other sources of informal support. These programs can be targeted to those to whom you want it to be targeted.

The third lesson to emphasize was that the case managers needed flexibility in the programs that they could offer. This theme has been emphasized repeatedly by previous speakers. If we excessively specify what services are legitimate, we tie the hands of the case manager. In my reading of the proposed title XXI legislation, the list of authorized services were very specific and the only service that was left for discretionary purposes was at the discretion of the Secretary of Health and Human Services.

Senator **Bradley**. Who is not going to be seeing many patients.

Dr. **Branch**. Exactly—who is not going to be seeing very many clients at all. I would suggest, therefore, that the case managers are the ones who need some amount of discretionary spending authorization available. They are the ones who have the responsibility of trying to solve the problems of the individual elders.

In this context, one of Dr. Kane's last comments about nursing home patients being sent elsewhere because they were not authorized to do sutures at their facility is a case in point.

I emphasize that a small amount of flexibility is necessary at the level of actual service delivery if the case manager is to meet the needs of individuals. I think the authorization legislation can emphasize what kinds of services are thought to be most important in today's circumstances, but remember that the a legislation is for tomorrow's problems also.

The fourth point to be made from the Massachusetts experience is that social service program moneys can be coordinated, but we do not have experience with coordinating large amounts of both social service moneys and medical service moneys.

The model in Massachusetts was more similar to the channeling model which is primarily a social agency approach. In that context of a social service agency having the lead and the responsibility for the coordination of care for the individual, we can coordinate, we can target, we can be reasonably cost efficient.

If the physician or someone from the medical care component is the dominant team member, or the gatekeeper, I am not exactly certain what to expect because we have not had an experience in that——

Senator **Bradley**. What to expect in what sense?

Dr. **Branch**. In terms of the ability to target, to be cost-efficient, and to provide the necessary services in a timely manner. I would be leary that the medical care gatekeeper would come in and spend minimal time signing forms and be titularly responsible, while someone else had defacto responsibility. We could easily be fostering a mismatch of responsibility and authority.

Senator **Bradley**. There is one preliminary study result in San Francisco where they had a hospital home care program that shows that part A of medicare, the hospitalization, was reduced by 50 percent, particularly rehospitalization, with this kind of aggressive home care program. Do you have any similar tracking in Massachusetts?

Dr. **Branch**. Yes; we have a similar experience in Massachusetts with a coordinated medical home-care program. My colleagues summarized their findings in the New England Journal of Medicine. They reported an overall reduction in utilization of the more costly services for those in a less costly home-care program. In the long run, this approach can save the Federal Government money because the elderly population is ever expanding.

The reason I am emphasizing the size of the eligible population is that sometimes we can get lulled into thinking that if we can shut down our administratively necessary day or reduce our length of stay in acute care hospitals, we will experience a net savings.

At the moment I do not think we will experience net savings because those beds are seldom vacant. If we think that providing an alternative tc institutional long-term, care in the short term could provide a net savings because there will be 100 beds or however many that are not being used, I think we would be making a mistake. That is not likely to occur.

But, if we are mindful that in the next 5 to 10 years we will have an ever-increasing denominator, or total eligible elderly population making demands on both the acute care beds and the long-term care beds, then it becomes much more reasonable to assume that we can reduce the rate of growth for acute beds and thereby save in elderly per capita costs, but not in net costs. Five years from now, we might not need as many acute beds per thousand elderly, and the current number of acute care beds we have will be sufficient for a larger population. That is where the cost savings can occur, not in the short term, but in the next 5 to 10 years, when the population base has expanded and the acute bed supply has not increased as much.

Senator **Bradley**. Let me ask you one last question.

What is your opinion about how far we should attempt to marry the social and health support systems? We have talked the whole range of services, from meals-on-wheels to nursing home admittance procedures and hospital reimbursement procedures. How much is it desirable and how much is it feasible to integrate the social and medical support systems?

Dr. **Branch**. I think it is highly desirable. I also think it will be difficult to accomplish in the short run. Nevertheless, if we are going to pursue a system of care that is most appropriate for the older person, we are going to have to go as far as we can in merging the health and social service systems.

Again, you had examples today of the negative consequences of the lack of integration: the lady who was receiving the multiple medications. If some one person were to coordinate and/or integrate her care, the problems caused by multiple medications might have been observed earlier on. In this example it was the social service component that identified the problem.

I am not trying to apportion blame in this example, but to emphasize that all the components are going to have to work together if our primary objective is the benefit of the individual.

Senator **Bradley**. What about the problem of the lower level of need? A lot of patients that we hear from on the Aging Committee don't really have acute Care needs, they have lower level needs. Is there a gap here between those with lower level and higher level needs in devising the system of service and medical attention?

Dr. **Branch**. I am not certain that I understand that question. I have an answer. It might not be the one to the question you are asking however.

Senator **Bradley**. We always think of the most comprehensive long-term care ranging from meals-on-wheels all the way up to the most acute care facility, or medical treatment. And the question is, Is there a cutoff point along this continuum where social services really should have less emphasis and medical services have a greater emphasis?

Dr. **Branch**. I am certain that there is. I think that it has also been reflected in many of the comments today, that as one progresses along some kind of continuum from independence to dependence there is a time at which medical care providers are going to have to assume a more dominant role.

There is also a point along that progression in which the economies of scale are such that it will become more cost efficient and probably more humane for the individual to shift the focus of support from community to an institution.

I would also have to agree very strongly with most of the comments that Dr. Kane made in this same context. There are no clear standards of care for geriatric health care or medical care. But I think any standards should revolve around maintaining maximum function for the individual. And if that becomes the goal, then there are certain things that the social service network and providers do that end and there are certain things that the medical care providers do for that end. They are different but complementary, and need to be coordinated.

Senator **Bradley**. Thank you very much, Dr. Branch.

Dr. **Branch**. Thank you, sir.

Senator **Bradley**. Now we are at that part of the program where people in the audience may make their statements or ask questions from the floor. When you speak, please speak at one of the microphones and give your name, address, and title, if you have it. The most important title, of course, is citizen. Feel free at this time if anyone wants to make a staement or comment.

I might say that Dr. Lena Edwards is in the audience. We welcome her. She was chairman of New Jersey's Delegation to the White House Conference on Aging, and we are pleased to see her here today. [Applause].

Yes, sir, please use the microphone.

STATEMENT OF GEORGE A. HAYDEN, LAKEWOOD, N.J.

Mr. **Hayden**. My name is George A. Hayden, National Council of Senior Citizens, Ocean County, N.J.

I have been working under the program of CETA for 1½ years but, of course, with the Reagan economics I have been taken out of circulation, because they can't find $3.90 an hour.

In my travels of a 105-square-mile territory I come on every conflict with the senior citizens aged 62 and up. I have taken care of doctors' lawsuits to the aged, the PAA, the rent subsidy, the food stamp program and all along the line of help to the senior citizens, which goes far deeper than just what I had mentioned.

However, it came to my attention the other day that private programs, as you know, are trying to come into the service of senior citizens. This alone cannot be a reality in taking care of senior citizens in the State of New Jersey. We have too many elderly. We have a problem of geographical layout. We have the big city of New York on one side. We have the Philadelphia City on the other side, and that brings more senior citizens into the State of New Jersey, like in Ocean County.

That is a problem for the county, and we have to be considered as a State as well as a county. How are we going to maintain the sick benefits of seniors when they are going into hospitals and nursing homes at the rate of 7 out of 10?

This past year there was a tremendous influx, but since I was taken out of circulation due to Reagan economics, I am not letting up. I am going to fight, and I am doing it all on my own, and on my own cash.

I am 101 percent with Dr. Kane. Hospitals can and must maintain home service or a nursing home service, expecially in the nursing home field.

I have been working on various cases. Here is one that came to my attention in the past 3 weeks.

This is a private organization called Area 7 Professional Standards Review Organization, Inc. from East New Brunswick, N.J.

Now, what the letter means: A patient was in the hospital and no more care could be given, so stated the PSRO. And they gave a date to the patient. On a certain date, June 24, 1982, no expenses will be taken care of, and you will be on your own.

Likewise, the doctor gets the notice, and the hospital social director is supposed to go out and find a nursing home for this patient. This patient is so far gone that no operation, no medicine will ever take care of her. So, when it was called to my attention by her sister, who had a stroke and can't handle her at home, she pleaded, "What can I do?"

Now this is common, very common with senior citizens. I can cite a dozen cases and I wish I had a committee to go with me to the nursing homes which I go into, to straighten problems out for these people that are cut from service, and no agency is coming in to help them.

Well, to get back to this particular case, this woman pleaded for help. I went from one nursing home to another and wanted to know, "Can you accept this party." And I showed them this letter. I spoke to the director of the hospital. He said, "I'm phoning all nursing homes for a bed and I can't find one." I went to one nursing home and the assistant director said to me, "Well, we have to have 45 patients who are medicaid patients in our home and the rest are private. Can this party pay $45 a day and up 2 months' money as a deposit?" I said, "No, this party is on medicaid, SSI, and so forth. Can you accept her within the next week?" He said, "I have no openings."

I went to another nursing home and laid this letter on the desk and asked them to check it—could they give me a bed, temporarily, so the person will be cared for. I was lucky, they could. And 2 days later the doctor in charge of that nursing home notified the hospital and this woman had the bed.

Now that is a mild case. But people in nursing homes are not getting the service they should, as Dr. Kane said. The medical service is not what it should be in a nursing home, unless it is protected and cared for by the hospital where that patient came from. We are spending $1,400 a month for a medicaid patient and they are not getting the service.

I had another case where up in North Jersey a patient with epilepsy deteriorated to the point where the nursing home could not handle the service, and I went to medicaid and I laid it on the line. We've got to put this person in a home that takes care of this type of illness. "Nope, we can't do that. We have no beds."

I said, "Well, let's put a survey out. You tell the nursing home to look for beds and I'll go to certain nursing homes and find the bed." So I put the pressure on the nursing home I thought could handle that type of patient. Luckily enough, it took 3 months of paperwork and social workers and I found this bed, and the patient today is sitting up in a chair, where in the other place she was laying in bed and hollering for medication to kill her pain.

I requested that nursing home, "Put her in a hosptial. Get a reevaluation. Where is the blood test once a month for this type of illness? Where is the proper diet for this patient? Under medicaid she is entitled to false teeth. Why didn't you order false teeth?" I went through the whole business of what we want to give a patient but the nursing home stopped it.

It is so discouraging to see these old people in bed hollering. I was in a nursing home Sunday. I try to get there at mealtime because I know there is a shortage of help. The people that haven't got the use of their hands are served last and the meal is cold and, of course, most of it is all homogenized or through the blender because they have no teeth.

So, I try to get there and I try to feed them. And in doing so I have seen patients laying in bed, as you go down the hall, suffering, crying, shouting from pain, "God, take me and kill me."

This is not American nursing care. It is profiteering by administrators running these homes. I can go right down the line and give you actual facts. I am not going to take all afternoon to do it.

I want to say just one more thing. We need to revolutionize nursing service under the jurisdiction of the Government to where nobody can come from a private agency—like a PSRO—can go into home or hospital and supervise health care.

The next thing we must do is we must get a State ombudsman with a proper staff and go in these nursing homes more often. A woman said to me the other day, "Oh, that patient of yours, she keeps me awake all night." So I said to this Teresa, "Did you wake up and keep the patient across the hall up all night?" She said, "I wake up with such pain. Nobody listens to me."

She can't use her hands to push the button so it lights up at the nurse's desk, so they put her at the end of the hall in the last room and let her holler. My only salvation was to get the doctor. And I got hold of the doctor and I said, "Doc, how many times do you go in to see this Teresa?" He said, "I'm there once a month. She is allowed a visit once a month under medicaid." I said to him, "Doctor, will you analyze her medicine? Why does she wake up hollering and crying and waking up all the people around her because she doesn't have the proper medication?" He said, "It is right on the chart. Whenever that patient wakes up during the night and needs medicine the nurse should administer it." But the nurse didn't. She went in and closed the door and let this patient holler.

Senator **Bradley**. I am going to have to move on. We have a number of other people. Let me just say the points you have made are, in many senses, well taken. What we are trying to do with title XXI is create some flexibility in the system so that we can make sure that the care system is adaptable to patients. Let me say on your last point that your insistence that Government actually have a role in insuring the standards of nursing homes is probably the main reason that I strongly opposed, and did so in writing, along with every member, Republican and Democrat, of the Aging Committee, the administration's decision to essentially give responsibility for nursing home care standards to a private commission, the Joint Commission on Accreditation of Hospitals.

We don't let Wackenhut, for example, protect the President of the United States. We have the Secret Service do that, as one Senator pointed out in the Aging Committee. And I think we don't want a private, nonprofit organization, or a private profit organization determine the standards for nursing homes in this country. We want the Government to do that because ultimately it is our responsibility to insure public health and safety, so we try to address those.

We really should move on. We don't have a lot of time left and I appreciate your comments, and also, from what you said, your efforts.

Mr. **Hayden**. One last comment. New guidelines for nursing homes should be put in that bill, then they cannot flimflam and mistreat patients.

Senator **Bradley**. Yes, ma'am.

STATEMENT OF LINDA WALLER, INCOME MAINTENANCE TECHNICIAN, BURLINGTON COUNTY, N.J., WELFARE BOARD

Ms. **Waller**. My name is Linda Waller, I am employed as an income maintenance technician at the Burlington County Welfare Board. The purpose of my job is determining financial eligibility for the medicaid and food stamp programs for the elderly and/or disabled.

As a result of my job, I am in constant contact with the elderly and their families.

Unfortunately, due to the lack of communication between the various agencies and the community, many people are unaware of the medical services and their benefits under medicare and medicaid.

Many of our referrals are from social workers and area hospitals or visiting nurses.

Hopefully, we can educate people and make them aware of the various medical programs that are available. If I may suggest, the media and literature sent with social security, Veterans Administration, and supplemental security income checks may be viable sources.

Senator **Bradley**. You are saying basically we need better coordination and information sharing with the elderly population?

Ms. **Waller**. Yes.

Senator **Bradley**. Thank you.

Yes, sir.

STATEMENT OF GEORGE E. EMERY, POINT PLEASANT, N.J.

Mr. **Emery**. Senator, my name is George E. Emery. I am currently working on trying to set up a volunteer program which will be in about 119 communities and four counties in the area of health care for the homebound.

In getting ready for this I ran across some information which I would like to call to your attention and hope we can have it admitted.

Senator **Bradley**. It can be submitted to the record if you would like.

Mr. **Emery**. What it is is an article[1] that appeared in a magazine, Columbia. It is entitled "Health Care for the Homebound," and it describes a program which is in operation, and has been in operation in St. Vincent's Hospital in New York City.

I contacted the staff there and I promised Robbie Liffsman, the executive director, that I would present this at this hearing. They were overjoyed to hear that it would be presented. And in the data I left with your associates I have the copy of this article[1] which I read and also a copy of the first publication of the Pride Institute Journal of Long-Term Health Care,[1] and also the St. Vincent Hospital and Medical Center of New York publication, "Nine Years of Long-Term Home Health Care."[1]

Now there are 9 solid years there from one of the most reputable organizations in the United States, and I think, if you could get your staff and your people on this you could find much that would be helpful in formulating national policies.

And as to my own personal feelings after hearing some of these thoughts here, especially the doctor with his comments, and thinking back on the White House Conference on Aging process we went through, there was a recommendation which never seemed to get through the maze of information. It was a recommendation made that all Federal funding be withdrawn from any medical school or nursing school, et cetera, that does not have a training program in geriatric medicine mandatory for all students.

With the big explosion coming in older people and the medical profession not ready for it, that is really asking for trouble.

Then, another thing: I haven't heard a single comment from any of these programs about the fundamental grassroots efforts which are going to make any of these things really work. That is, getting out and ringing the doorbells and finding these people in the community before they become problems. There should be more accent on prevention.

And then, you hear about the lady that just preceded me, who mentioned about all this information you have to get from somewhere. Now in this age of computerized technology, we certainly should be able to come up with a resource directory of information accessible to anyone without having to get at half a dozen social workers and organizations to get the information for you.

Senator **Bradley**. I think that the county offices on aging really should have available to senior citizens that list of programs. If you could submit that—give me a copy of that, we will make sure that those articles are studied. I would like to read it myself.

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[1] Retained in committee files.

Mr. **Emery**. I gave it to the other lady. I forgot her name.

Senator **Bradley**. You gave it to Miss Deignan?

Mr. **Emery**. Miss Deignan, that is right. And she said she would give it to you. And I want to thank you for your time, Senator.

Senator **Bradley**. Thank you for coming.

Yes, sir.

STATEMENT OF EDWARD WOJCEK, VICE PRESIDENT OF BUSINESS AFFAIRS, POLISH CULTURAL FOUNDATION, IRVINGTON, N.J.

Mr. **Wojcek**. My name is Edward Wojcek and I am from the Polish Cultural Foundation. We are in the process of buying a school in Clark, N.J. There we are going to have about 40,000 square feet of floor space. It stands on 3.8 acres of land. Therefore, there will be abundance of space for our particular need.

Should this program need additional space, contact us, we will cooperate.

Senator **Bradley**. Well, let me thank you very much. Can you make sure we have your name and also the address.

Mr. **Wojcek**. Right now we are going to have contractors, this week, looking through the building, what changes will have to be made for our needs. These people will act promptly. We will make the changes with the proper funding to accommodate whatever is needed.

Senator **Bradley**. Very generous community-spirited offer and I am sure that if the people in here didn't hear it, the seniors in the State will, and I am sure will be in contact. Make sure we have your address.

Yes, sir.

STATEMENT OF LOUIS ZELMAN, PRESIDENT, HOMED, INC., MOUNTAIN LAKES, N.J.

Mr. **Zelman**. My name is Louis Zelman and I am president of HoMed, Inc., a major supplier of home health care products and services in New Jersey.

We recognize that there are medical circumstances which necessitate that hospitalization and nursing home care be provided to the elderly and disabled. However, a closer coordinated planned approach between the medical community, the hospital, the nursing home community, and the home health care private sector must take place in order to produce quality health care in the most efficient and cost-effective manner.

For example, the creation of a community-based informational network designed to educate and raise the awareness levels of the elderly and disabled with respect to the essential health services available, should be considered.

Two, there should be a recognition of the need for a logical transition of the elderly and disabled from the hospital or nursing home to a home setting.

Three, a team effort among health care professionals, agencies, institutions and patient advocates should be made with respect to the design and establishment of a practical approach which copes with spiraling health care cost.

We should not realistically expect to go from a bold beginning to full accomplishment overnight. What has been proposed here briefly require continual planning, involvement, commitment, and followthrough by the very groups which stand to benefit most from the provision of these essential health services, mainly the elderly and the disabled.

Maybe the time has come for the experts to stop telling the elderly and disabled what their requirements should be. The elderly and disabled should, instead, be encouraged to express their own ideas and develop their own goals. A team approach should be utilized to help them achieve these goals.

Thank you very, very much.

Senator **Bradley**. Thank you very much.

Yes, sir. Mr. Gallagher.

STATEMENT OF BERNARD J. GALLAGHER, NUTLEY, N.J.

Mr. **Gallagher**. My name is Bernard Gallagher, and I want to congratulate our Senator for the strong support that he has given to our senior citizens.

We heard a lot of testimony here today, and a lot of it was on nursing homes. I am a 75-year-old senior citizen and the last place I want to go is to a nursing home. I would like to just speak a little bit on congregate housing.

I think nursing homes should be an alternative to congregate housing. If we had congregate housing, our seniors could receive many of the things they need right under one roof. We would have a home health aide, we would have nutrition, we would have a podiatrist, and they would be taught self-care, and how to take care of one another. I think that we would have a community room where they would be able to have arts and crafts, and of course, where you have seniors you have bingo, right?

I don't think there is enough said about congregate housing. Not only that, we have section 202. We have section 8. We have title XX. All could work together and there would be no need—there would be exceptions—but there would be no need to send a lot of our seniors to nursing homes if we had congregate housing.

Just let me briefly speak on medicare. I think medicare is being slaughtered in Washington and I think it is a hoax perpetrated on our senior citizens. Right now our senior citizens are paying 68 percent of their health bills. What I would suggest Congress do is take medicare and get it out of the hands of the Government and say, here, we are going to submit this out on bid and we would ask all the insurance companies in the United States to say, here, give us a sound medical policy, close all medical gaps for our senior citizens and let us know what it is and then we know we're covered.

Right now medicare is a hoax. Thank you.

Senator **Bradley**. Thank you very much, Mr. Gallagher. Let me just say that I share some of his sentiments. I think that some of the reductions in Medicare have been unfortunate this year and I think they will result not only in increased out-of-pocket expenses for senior citizens but simply transferring the cost as well to higher premiums for medigap policies.

Yes, ma'am.

STATEMENT OF RITA SCHWARTZ, DIRECTOR, OLDER ADULT DEPARTMENT, YOUNG MEN-YOUNG WOMEN CHRISTIAN ASSOCIATION, UNION, N.J.

Ms. **SCHWARTZ.** My name is Rita Schwartz. I am director of the older adult department, Young Men-Young Women Christian Association, Union, N.J.

I have been hearing a lot about long-term care, nursing home care. What we haven't talked about is families who want to keep their elderly loved ones at home and don't have the funding and available services. So what I would hope you would include is some thought to those people who need to have some kind of respite care and also some kind of financial reimbursement in order to keep their loved ones home.

Senator **BRADLEY.** Fine.

Let me say that the hour is fast arriving when we have to gavel this down.

Dr. Edwards, would you like to make a comment?

STATEMENT OF DR. LENA F. EDWARDS, LAKEWOOD, N.J.

Dr. **EDWARDS.** One of the things which I have been fussing about is that we need to take advantage of our group of people. The nutrition sites are wonderful places where we can teach people how to stay well. I believe in the wellness of age. I am 82 and I don't intend to go to a hospital again because when I was there in 1975, all they did was test, test, test and I came out no better than I am today.

So I think we have an overutilization of institutional care for senior citizens, and they should be able to stay out. I brought this from the AMA News,[1] of how it is being done in Florida, and there is no reason under the sun that we cannot get, with a minimum amount of expense, care for our senior citizens out of hospitals.

I will say this: When I came to Ocean County they had nothing for all those seniors. And they represent a concentration of senior citizens greater than in any place in the world. And when I told them, let's go to the nutrition sites, I got turned down, and I am still turned down. Although I sneak in once in a while and talk to them.

And one-third of our senior citizens are in the low economic branch or poverty. They sit home and eat bread and jelly and wear two sweaters in the winter. They are the people who built this country. It is a crime to know that they are not being taken care of because outreach means sitting in an office answering a telephone, not ringing doorbells.

But we went to the beehive when they refused to give us a screening program. A health screening program in which those who could afford to could pay $10 for the same thing that costs about $150 with your private doctor.

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[1] Retained in committee files.

And I reviewed all those cases. I have taken it on the rap. I have had my license threatened, and everything, for the things I do but I don't give a rap for it. I am going to do what I think is right for the human being, and for the patient, and especially for senior citizens.

I grew up with them, that is the way I learned gerontology. That is why when Seton Hall was at a loss for someone to teach gerontology, not geriatrics, this past semester, at 81, they hired me for free to teach gerontology.

We need to spend more time in studying the people as they grow older and developing in them a sense of security and being wanted. And if you did that I wouldn't have to be on the Marlboro Hospital Board representing senior citizens. I tell them I am here to keep seniors out of the hospital instead of seeing that they are taken care of in the hospital. Because if senior citizens are, first of all, taught to take care of themselves—exercise, simple diet, and a high opinion of yourself, they wouldn't need all this care. [Applause.]

Senator **Bradley**. I think that might be an appropriate moment in which to close this hearing. Let me thank all of you. If you have additional statements you may submit them in writing by mail. I thank you for your attendance at this hearing. It has been very beneficial to me. Thank you for your cooperation. The hearing is adjourned.

[Whereupon, at 4:45 p.m., the committee adjourned.]

APPENDIXES

Appendix 1

MATERIAL RELATED TO THE HEARING

ITEM 1. NEW JERSEY ASSOCIATION OF AREA AGENCIES ON AGING POSITION PAPER ON THE NEED FOR NONINSTITUTIONAL ACUTE AND LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED, SUBMITTED BY PETER SHIELDS, DIRECTOR, UNION COUNTY, N.J., AREA AGENCY ON AGING

As a result of a state-wide conference held during October 1981 in the State of New Jersey sponsored by:

The New Jersey Association of Area Agencies on Aging
The Home Health Assembly of New Jersey, Inc.
The Home Care Council of New Jersey
and
Senator William Bradley (D-N.J.)

wherein two hundred and ninety-six health care professionals and others concerned with the problems of our elderly and disabled discussed the need for new, improved and expanded home care services—we, as the Conference Planning Committee, hereby state our following position as a result of this conference:

A crisis exists in the State of New Jersey, and probably in other states, in health care as a result of a shortage of nursing home beds for our disabled poor. This bed shortage points up the need for new, improved and expanded home health care in order to prevent unnecessary nursing home placement and thus help alleviate part of the problem. Two things are happening simultaneously: The number of people needing long term care is increasing rapidly, and the costs for providing such care are growing dramatically. In a nutshell: government may have reached its limit in its ability to absorb increasing long term care costs at the same time that the population expected to need help with continuing care is growing. This creates an urgency to explore new alternatives in the ways of caring for people with long term care needs and in the methods of funding. Studies show that as much as 20% to 40% of the nursing home population could be cared for at less intensive levels if adequate community-based care was available. Caring for these people in nursing homes when they have the potential to remain in the community is a costly and inefficient use of resources. Right now, community services for the homebound are so disorganized that even trained staff have a difficult time overcoming the fragmentation and organizing a delivery of care from numerous agencies.

Specific questions addressed at the conference and their answers are:

1. QUESTION: How can we establish a coordinated system of services that will do pre-screening of nursing home applicants, assessment and case management through a single entry point in a geographic area?

   ANSWER: The conferees agreed that a coordinated system can be established that could do pre-screening of nursing home applicants, assessment and case management through a single entry point in each georgraphic area.

They state the existing federal Social Security Act should be so amended that it would consolidate its existing home care services legislation into one title, to which would also be added new and improved home care services;

that the amended law should require states to establish standard criteria to be used in selecting "the single entry point" and that consideration should be given to the following:

1. The Governor of each state should be encouraged to require a consortium approach at the state level wherein human services, aging and health agencies would be required to cooperate together in the establishment of a state Title XXI plan.

2. The local single entry point agency selected must have existing close relationship with all elements of the health and social services networks in order to act as an unbiased services coordinator.

3. Current providers of long term and community care services should not be selected because of the inherent danger of services skewing and lack of impartiality.

4. The entry point agency should be capable of developing procedures to guarantee that consumers be given a choice of services.

2. QUESTION: How can we avoid duplication of services in the same geographic area?

   ANSWER: In order to avoid duplication of services consideration should be given to Area Agencies on Aging as single entry point for services, as services coordinators, as umbrella agencies for medical and non-medical services who would employ pre-assessment teams of professional medical nursing and social worker personnel to screen applicants for services.

3. QUESTION: Title XXI provides for an important core of non-institutional long-term care services, but does not include meals, transportation, and other related services. Can the Title XXI approach serve as a focal point for directing and coordinating these and other allied services:

   ANSWER: Yes, the initial entry point agency can also act as a coordinator in arranging for cooperating agreements with these allied service agencies. Long term care requires close coordination between the health and social care systems to help all those who need a variety of services. It is absolutely essential that home delivered meals and other non-medical services be an integral part of the system. Consideration should be given to amending the Older Americans Act to permit extension of allied services to the disabled under age 60.

In view of the existing "hodge-podge" of services under Titles 18, 19, and 20 it is essential that they be brought under a Title XXI catchall which should also include Adult Day Care and Respite Care.

4. QUESTION: What are the advantages and disadvantages of proposals which would expand non-institutional long term care services under Medicaid only (as opposed to Title XXI's inclusion of such services now available under Medicare, Medicaid, and Title XX Social Services?) Can such more limited approaches serve as building blocks toward Title XXI's more comprehensive approach?

ANSWER: An advantage is that the expansion of home care service under Medicaid can provide statistical data, experience and a track record for developing services that can eventually be expanded under Title XXI.

The only disadvantage to Medicaid is the limiting of the services to the poor and the continuing "welfare" stigma attached to the service.

5. QUESTION: What are the respective roles and financial responsibilities of federal and state governments? Private insurance? Voluntary contributions from industry and business? Recipients of services? Their families?

ANSWER: The conference did not separate out responsibilities of the above but advocated that all of these need to be considered as potentials in the finance mechanism. Alternative approaches need to be explored and these include greater involvement by religious organizations, the business community, neighborhood groups and voluntary organizations to support activities that prevent or deter the need for high cost or continuing needs. More attention must be given to prevention and to creating incentives that reduce our reliance on expensive established practices.

They indicated that private insurance should be encouraged to cover expanded home health care.

It was felt that business and private sectors could not be counted upon for any type of funding, however, company health care plans were encouraged to include expanded home care services. Conditions should be created to help employers include certain long term care benefits as part of their employee fringe benefits. While some provide home health care, non-medical services like homemakers are not included in employee health plans.

Co-payments by families and/or patients were encouraged as well as the establishment of fees on a sliding scale with consideration of assets.

6. QUESTION: Should fees be charged on a sliding scale based upon income? What would be the effect?

ANSWER: Yes. The effect would be to cover all the medically needy.

7. QUESTION: Reference is made to financial incentives and encouragements for care of elderly persons by their families or non-related families. Can tax incentives or credits for such care lead to more home-based long term care?

ANSWER: Tax incentives for increased home care to encourage family care were recommended. In addition, tax incentives were also recommended for non-family members who might also care for the elderly in their homes.

8. QUESTION: Are there other financial approaches to encourage the care of the elderly in the home or community?

ANSWER: The conferees stated any incentive to improve home care must be explored that might delay or prevent institutionalization. A particular avenue which might be explored is direct reimbursement for family care of those aged persons who meet financial and physical criteria for government sponsored skilled nursing facilities care.

We state that regardless of these times of budget cutting that difficult decisions about costs and implementation of long term care services must now be made on the current critical issues we are facing and that each community in our nation must get organized around better, more coordiated long term care services.
Home care and community-based services are giving alternatives to institutional care and one giant step would be the enactment of the Senate and House Bill to to amend the Social Security Act to provide for a six-year demonstration program of community-based non-institutional acute and long term care services for the elderly and disabled under the following new title:

TITTLE XXI - NON-INSTITUTIONAL ACUTE AND LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED

Respectfully presented by:

Susan Walmsley-Ault, A.C.S.W.
Director of Social Work
Muhlenberg Hospital
Plainfield, N.J.

Peter M. Shields
President
New Jersey Association of
Area Agencies on Aging

Kenneth Dolan, Planner
The Urban Health Institute
East Orange, New Jersey

Kenneth Wessel
Executive Director
Visiting Homemaker Service of
Passaic County

Minority attestation by Winifred S. Livengood, Executive Director, Home Health Agency Assembly of New Jersey, Inc. agreed to as above with the following substitutions:

QUESTION #1, Recommendation #2 to read:

2. The local single entry point agency may be governmental or, through contractual arrangements, a community based organization. The agency should be selected on the basis of its having existing close relationships with the health and social services networks in order to be an effective coordinator.

3. Several models for the single entry point agency should be developed to reflect the variations in the county systems and abilities in New Jersey and to encourage efficient and economical development of the program.

QUESTION #2, answer to read:

In order to avoid duplication of services, consideration should be given to Area Agencies on Aging, County Departments or community based agencies to act as single entry points and umbrella agencies to provide pre-assessments for screening applicants, to be service coordinators and to provide services directly or through contractual arrangements.

* * * * * * * *

Recipients of this publication are encouraged to advocate for the passage of Title XXI of the Social Security Act covering Non-institutional Acute and Long-Term Care Services for the Elderly and Disabled through their federal legislators.

Peter M. Shields
President
NEW JERSEY ASSOCIATION OF AREA AGENCIES
ON AGING

ITEM 2. AREA AGENCY INVOLVEMENT IN LONG-TERM CARE, SUBMITTED BY PETER SHIELDS

Since the inception of Area Agencies on Aging, which were established under the provisions of the Older Americans Act of 1965, their role in long term care has gradually increased to the present point where we are greatly involved in vital services particularly for the frail, homebound elderly.

Home care is a vital element of long term care and while home care needs to be vastly improved the significant part played by Area Agencies must be recognized so that continuing efforts can more effectively concentrate on needed changes.

Taking the Union County Area Agency on Aging as an example of involvement in the prevention of institutionalization and the caring for those who need but can't obtain institutional care, the following are worthwhile statistics on our services involvement:

During 1981 we were responsible for serving 135,245 home-delivered meals and we provided for 17,890 nursing and homemaker visits. These were in addition to serving 232,181 congregate meals, providing information and referral 9534 times, assisting in transporting seniors 114,770 times, assisting in preventive health testing of seniors 7350 times, helping 109 terminally ill in a hospice program, administering grants for legal protective services, and elderly blind services.

We are in the continuing process of improving our service delivery system while concentrating on the sick, elderly poor and giving priority to the five essential basics for home care - the home-delivered meal, the nursing and homemaker/home health aide visits, essential medical transportation and competent trained Social Workers to aid the homebound with their varied problems.

At the present time we are serving over 500 home-delivered meals daily which make up 1/3 of our total daily meal production of 1500 congregate and home-delivered.

We are funding "A Coordinated Homemaker/Home Health Aide Service for the Elderly and Disabled residents of Union County" that provides nursing and homemaker visits so that those seniors whose services cannot be paid for from other sources (i.e., Medicare, Medicaid, private health insurance, inc.) can have their services continued insofar as our limited Title III and Title XX funding permits. This activity has definitely permitted people to remain in their own homes and is vitally necessary in view of our State's Medicaid nursing home bed shortage problems.

I am attaching a description of this program which illustrates part of our current effort to further improve our coordination of services for the elderly and disabled.

I strongly recommend that the aging network definitely be considered as the funding stream coordinator for assessment, case management and services delivery.

A COORDINATED HOMEMAKER/HOME HEALTH AIDE SERVICE FOR ELDERLY AND DISABLED RESIDENTS OF UNION COUNTY, NEW JERSEY

INTRODUCTION:

To achieve the maximized level of service and insure that services are directed toward the most needy, we have developed and are implementing a coordinated, County-wide home health system.

Home health agencies are autonomous and do not necessarily share information with each other. Thus it is possible for more than one agency to provide home health service to the same client without the agencies knowing about the service provision by the other. This fragmentation of service works to the disadvantage of a client because of the lack of ready access to service and the diminution of service due to excessive administrative costs.

The funds available for home health services have been inadequate to meet the need in the past. With the possibility of future funding being cut or remaining at current levels coupled with the growing need and the desire to maintain individuals within the community, there is a great pressure to maximize existing resources.

Within the County there are four sources of public funds providing home health services (Medicare, Medicaid, Title XX and Title III). Setting Medicare and Medicaid aside for the moment, we are primarily concerned with Titles XX and III. The latter two funding sources were going to several agencies withing the County, (i.e. County Welfare, Elizabeth Housing Authority, Jewish Family Services). These funds have now been pooled and held by an Administrative Unit of our Area Agency.

OUR GOALS:

1. To provide uniform home health aide service throughout the County.
2. To produce the maximum level of service from available resources.
3. Provide centralized:
   (a) authorization for service and disbursement of funds.
   (b) data collection on client information.
   (c) client referral.
   (d) client intake record keeping.

4. Provide decentralized service through existing certified home health agencies and adjunct service providers.
5. Develop universal definition of home health services terms (i.e. homemaker/home health aide, chore service, etc.)

SYSTEM CHARACTERISTICS:

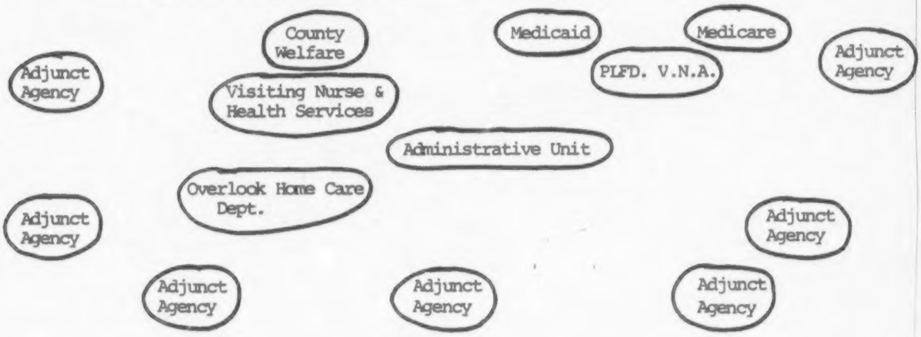
I. STRUCTURE:

The characteristics of this system are based on recommendations from planning groups comprised of funding sources and direct service providers.

The Coordinated home health system can be viewed as a solar system. There is one focal point receiving Title XX and Title III funds: the Administrative Unit. The Unit, in turn, purchases services (as appropriate) from one of the existing certified home health agencies. The certified home health agency provides service directly or sub-contracts with one or more of the adjunct agencies. The Administrative Unit does not provide any direct services to clients beyond intake (or the recording or intake, if it takes place at another point) and referral.

The essential feature of this system is the division of responsibility. By implementing this plan, Union County is in the vanguard of areas capable of complying with anticipated regulations. This system brings Union County into compatable position with anticipated Federal mandates when Title XXI demonstrations become obligatory. However, the major improvements this system provides are benefits to the client population and agencies providing home health services to those clients.

A one dimensional view of the three dimensional system:


County Welfare
Medicaid
Medicare
Adjunct Agency
PLFD. V.N.A.
Adjunct Agency
Visiting Nurse & Health Services
Administrative Unit
Overlook Home Care Dept.
Adjunct Agency
Adjunct Agency
Adjunct Agency
Adjunct Agency
Adjunct Agency

II. FUNCTIONS

Units	Functions
County Administrative Unit	1. Data Collection: Clients, Units Delivered, Funds Expended and Available.
	2. Rate Setting
	3. Service Plan Authorization
	4. Purchase of Services
	5. Payment Authorization
	6. Monitoring against Service Plan and funding use.
Certified Home-Health Agencies	1. Screening
	2. Intake: Eligibility Determination, Service Evaluation, Preparation of Service Plan
	3. Case Management
	4. Service Provision
	5. Payment Arrangements for Medicare and private carriers.

A. County Administrative Unit

1. Develops and implements standard Title III & XX admissions criteria and priorities for use at all intake points which target the "most needy" population. Also improve outreach towards that population.
2. Mandate uniform agency based training (in consultation with participating certified home health agencies) approved by the N.J. Department of Health for all aides providing home health services paid by public funds.
3. Develops a universal, generic job description for aides which incorporates all possible activities; mandates the performance of all such activities.
4. Develops, adapts, applys and monitors appropriate and reasonable service standards across the system.
5. Clarifys current service limitation of each funding stream and develops consistancy across the system to minimize service inequities and dislocations.

6. Estalbish as rates and units of service in consultation with participating certified home health agencies.
7. Develops universal forms for intake, client assessment, payment authorization, etc.

B. Certified Home Health Agencies

1. Screens all applicants to determine appropriate service needs and eligibility.
2. Develops service plans including case management for eligible clients.
3. Works in concert with Administrative Unit to develop, implement and where appropriate, change the system.
4. Establishes catchment areas for each cooperating certified home health agency by geographical or other means acceptable to the home health agencies and the Administrative Unit.

III. ADVANTAGES OF THE SYSTEM:

1. Improved targeting on "most needy" population.
2. Equity for clients in Admissions process and receipt of services.
3. Improved data collection in area of:
    a. Client tracking
    b. Documenting and seeking means of meeting unmet needs.
    c. Tracking expenditure of resources.
    d. Magnitude of service.
4. Expansion of service by eliminating duplication of service and monitoring of services rendered.
5. Improved access by allowing entry to system at any point.
6. Compliance with Anticipated Federal mandates.

7/26/82

ITEM 3. CASE HISTORIES, SUBMITTED BY ROSEMARIE CUCARRO

CASE #1

Middle income family; independent all their lives; 1 child.

Retired from work; electronic technician.

Husband - had CVA - left-sides paralysis; did well; family able to care for self.

1977 - husband fell and fractured L hip; also diagnosed Parkinson's Disease.

1978 - wife unable to cope; moved in with son and daughter-in-law (who works).

1980 - wife diagnosed as Ca. Breast - had radical mastectomy; left with limited use of L arm.

Family hired private help daily to care for husband.

1982 - Husband fell and fractured R hip; pinned hip. Home from hospital with decubitis. Confused; needs assistance of two to stand, non-verbal, rigid; needs to be fed.

Family now financially unable to afford care privately.

As of March, decubitis healed; physical condition stable. No longer eligible for Medicare coverage.

Plan: continue aide 2 hours per day; family pays $4 a day; $20 a week.

Nurse continues to visit twice a month - Title III for part-fee coverage.

CASE #2

Poor family but able to manage.

Husband, age 42 - Wife, age 34

2 children - age 14 (girl) and 10 (boy)

Husband had left and right sided temporal parietal infarct - lost most of vision and speech; left hemiplegia.

Major depression in hospital (2 months); refused to eat. Discharged with Naso-Gastric tube.

Wife - had artificial hip; lack of any skills to care for husband.

No insurance; total income $650 a month.

Plan: Aide 1 hour per day; 5 days per week. Nurse 2 times a week.

Physical therapy evaluation - set up plan of care to be followed by nurse and aide. Physical therapy was free.

After two months, feeding tube out; patient becoming independent in physical care.

Nurse and Aide - Title XX

CASE #3

Husband, wife and 3 children (boys)

Wife, age 49

Children, 14, 18 and 21

Husband - income $17,320 year; wife also worked prior to illness.

1981 - wife had subarachnoid hemorrhage leaving her with left hemiplegia. Husband also had cerebral aneurysm - successful surgery.

Family has health insurance and Major Medical. Does not cover aide services; 80% of nursing, physical therapy and occupational therapy.

Wife unable to care for self; in wheelchair; catheter with many problems.

Now very depressed because of her inability to contribute to family needs as well as caring for own ADL.

Husband desperately trying to work; assists wife and be father to children.

Title XX for aide and now nursing under Major Medical is getting close to maximum and will be transferred to Title XX.

Please assist those of us who are trying to meet community needs. Equalize income eligibility under the Medicaid program.

Make Title XXI a reality so we can put all our energies into caring for real people instead of trying to find a funding source to provide care.

I have addressed home care but I am acutely aware of gaps in service and the need for other alternatives in addition to home care. We (including home health agencies) must address health day care, innovative and specialized housing arrangements and 24 hour care.

Thank you for inviting me to comment and for your attention and support.

Rosemary Cuccaro
Executive Director

ITEM 4

SENIOR CITIZENS COUNCIL OF UNION COUNTY, N. J., INC.

Senior Citizens Consumer Education Program

2165 MORRIS AVENUE
UNION, NEW JERSEY 07083
TEL. (201) 964-7555

EVELYN FRANK, DIRECTOR

July 26, 1982

Senator Bill Bradley
2107 Dirksen Senate Office Building
Washington, D. C. 20510

Our organization, the Senior Citizens Council of Union County, N. J., Inc., feel that some of our comments would be useful today and wish to submit this report.

Firstly, to introduce ourselves:- The Senior Citizens Council of Union County organized in 1971, has representation from approximately 50 Union County senior Citizen groups and has advocacy as its prime goal. In 1977 we were funded by CETA to open an office to better serve Union County senior citizens and currently a grant from the Union County Division on Aging helps us to continue to assist our older population.

Two of our most effective programs is a Comprehensive Dental Referral Program and a Senior Citizens Employment Program which does Job Development, Job Placement, Job Match and Counselling. The job orders in our program include job place, mostly parttime, in the private sector. Many of the job orders are for assistance to the homebound privately paid for in order to avoid institutionalization.

Our Home Support Job Orders are placed by the family, agencies, i.e. Visiting Nurses, and the elderly themselves. The fee, usually arranged between employer and employee, is minimum wage. There must be many elderly living at home who do not contact us because this minimum fee is more than they can pay. Requests come in for light housecleaning, chauffer service, companion, to cook salt free meals, live in companion, supervision in cases of slight senility.

When I ask if Meals on Wheels could be used instead of cooking in the home, we encounter resistance because the preparation of the meal brings a person into the home who would attempt to create a feeling of independence and companionship.

At times the family needs counselling in order to better understand the elderly. Mother, even if she is 90 years of age, resents a companion to sit and look at her. So we suggest we call the companion a "Friendly Visitor" who has only popped in to say "hello" and is everything alright.

Dad comes to live with the family and they want to do everything to make him happy but they forget to see what it is he can do to help them and feel useful again.

If there are some physical problems we will call the Visiting Nurse & Health Association to check out if the patient is in the system and is being seen by a nurse.

We feel certain that our report would be typical of the needs of many homebound elderly, and the number of frail elderly is on the increase, and our Employment Program is striving to fill the gap that will enable people to stay in their home as long as possible.

Respectfully submitted,

Evelyn Frank

Evelyn Frank, President/Director

P. S. Enclosed is a sampling of our Home Support Job Orders.

Enc.

Age	Job Order		Referral
90	watch her 3 times a wk, no housework	legally blind	family
97	drop in twice a day and visit her		family
90	Driver her on errands, to doctor		Self
91	8 hrs a day, full time, companion, her arm is in cast		family
92	needs meals, nothing else, stay or live in while family is on vacation		family
90	Prepare dinner five days a week , no need to shop		Family
90	Companion		Family
90	Confined to bed, fix lunch, bedpan, straighten apt.		Family
91	Companion for mother, light cooking		Family
83	Arthritic, legally blind; take her to doctor, light cleaning, one meal, be a companion		
84	Senile mother, language problem		Agency
83	Husband needs watching every other day, 3 hrs		family
83	Blind woman, evening hours, meals		Family
88	Companion for mother, should be Friendly Visitor		Family
86	Sleep in, help to bathroom at night, help dress		Family
80	Live in Companion for mother		Family
79	He has difficulty walking, to sit with him, one meal		Agency
76	She has Parkinsons, needs someone who will make her to to do things, is not motivated		family
73	Man needs housework, twice a week,		Agency
73	Take mother to market, beauty parlor, do laundry, house cleaning, might be forgetful		Family
70 +	Help man into wheelchair and bathe		Family
75	Live in Companion for mother for two weeks		Family
70	Companion , help him to bathroom, watch him outside		

lor Citizens Council of Union County, N. J. Inc. 7/82

No age given	Job Order	Referral
	Someone to drive her shopping, bank, etc.	Self
	Mother needs an injection once a day	family
	Patient recently blinded, when out of hospital will need assitance	Agency
	Prepare salt free dinner and assist hubband with tasks	Self
	Companion for elderly, bad eyesight, senile	Family
	Full time companion, had stroke	family
	Light housekeeping, sponge bath, cooking	Family
	Occasional Companion for elderly man	Family
	Housework for man, twice a week	Agency
	Light housework, once a week, is in walker nurses aide is in a.m.	Self
	Cooking salt free and little shopping	Agency
	Will pay $10.00 to shop groceries in bad weather	
	Companion once a month, at times senile	
	Needs insulin shot daily	Agency
	Companion, light cleaning, cooking give bath, walks with cane, is feeble	Family
	Companion, 3 hours, 3 days, mother in wheelchair	Family
	Cook for man, clean, shop, clean	Family
	Husband needs cleaning help while wife is in hosp.	Agency
	Take her shopping, help with checkbook, legally blind	Agency/self
	Occasional sitter for elderly mother, walker	Family
	Drive her to sthop, had stroke	Self
	Live in Companion, no cleaning, cooking	Self
	Housework, little cooking	Self
	Room & Board, light duties & small cash allowance	Self

Senior Citizens Council of Union County, N. J., Inc. 7/82

Appendix 2

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committe to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR BRADLEY: If there had been time for everyone to speak at the hearing on "Long-Term Health Care for the Elderly," on July 26, 1982, in Newark, N.J., I would have said:

[The following replies were received:]

EVELYN COHEN, MERCER COUNTY SENIOR CITIZENS OUTREACH PROGRAM, TRENTON, N.J.

Please be sure to include outreach services in planning for coordinated services in long-term care.

Many of the elderly live alone, in isolation, and are never heard from until a crisis brings them to the attention of the social service and health agencies. It is therefore vitally important to use outreach services to seek out these isolated elderly and bring them to the attention of the service agencies. Also, the outreach worker becomes the only link to the outside world, and frequently is the only source of human contact for homebound and handicapped elderly.

JAMES FASCIANI, JEWISH VOCATIONAL SERVICE, EAST ORANGE, N.J.

The supportive services provided by vocational rehabilitation programs for the aged are of vital importance. They provide meaningful work activities for may senior citizens who continue to have a need to be productive. In addition, the socialization with coworkers serves as an excellent means of preventing total isolation.

NELLIE GRIER, EMMANUEL SENIOR CITIZENS DAY CARE, NEWARK, N.J.

Nursing homes are good for people who are maybe bedridden, but for seniors who are able to help themselves I think day care is better. This means that they will not have to stay in the house all day. Also, they would be brought out every day and mingle with her or his age group, and attend different functions such as ball games, picnics, luncheons, and other things.

Visit us sometime.

JENNY ROSENDORN, BURLINGTON COUNTY WELFARE BOARD, MOUNT HOLLY, N.J.

The phasing out of the State medical assistance to the aged program was a real loss to persons over 65, who need home health care. We were told not to accept any more applications after July 1, 1982, because the State could no longer fund the program.

If those in the State government would only realize that the cost of nursing home care is the larger expenditure of the two, I think they would have thought twice about bringing this program to such an abrupt ending.

FRANK SCHOCK, NEWARK, N.J.

The rich get the tax, the poor get their throat cut. We have billions of dollars for bullets and Defense Department and the oil barons instead of balancing the budget off the backs of the poor senior citizens, social programs, and schoolchildren. Human beings are more important to me than the oil baron billionaires and the Defense Department.

SALEMMA A. TURNER, NEWARK, N.J.

I would like to say I feel one person could have one person living with the seniors for night services due to illness. Since there have been so many of them found dead alone.

BELLE WEISS, ESSEX COUNTY DIVISION ON AGING, MILLBURN, N.J.

We need to develop lesser skilled custodial workers to make home care a reality.

MARK S. YARNOLD, ACSW, MONMOUTH MEDICAL CENTER, LONG BRANCH, N.J.

Senate bill 1958, Expanded Home Hospice Care, can be directly linked to S. 861 (title XX legislation) in that services can best be provided both medically and socially at home or in a nonacute hospital setting.

Much depends however on third-party recognition of this feeling and that payment can and should be made for services traditionally provided in an acute care setting. Naturally the administration of these services will be provided by the visiting nurse services, social service agencies, etc., and funds should be allocated in that direction also.

As most hospice eligible individuals are defined as such during a stay in an acute care facility, hospice units within a hospital setting should be supported as identifiers of transitional need post discharge from the hospital.

Unfortunately many individuals must rely on expensive inpatient stays simply because of the lack of relatively simple support systems at home.

CAROLYN ZAGURY, R.N., MONMOUTH MEDICAL CENTER, LONG BRANCH, N.J.

Monmouth Medical Center, Long Branch, N.J., has, for the past 3 years, been working with the rapidly growing elderly population in order to address an appropriate range of services to meet the patient's needs. We have recently designed our approach as a team effort with members coming from all specialty areas within the acute care setting and from the community-based agencies. The patient is assessed and followed through their hospital stay with a continuous reassessment of needs for return to the community. Consults are requested from the team member capabilities (pharmacy, respiratory, PT, OT, social work, etc.).

A functional level evaluation is completed by the PT and OT department (with physician order). Concurrent therapy programs are designed to meet the patient's needs and capabilities during the acute episode. We will begin a "Cooperative care for the elderly—family training program" in the fall. This program is designed to help families and caretakers learn to provide essential care services to the patient in the community. Especially those services which must be provided beyond those reimbursable hours.

The individual cases are assigned a primary case manager. The manager requests the necessary consults and acts as coordinator for the patient, the family, the physician, the agencies, and the geriatric team. Case management is transferred to the essential home base agency with weekly followup back to the geriatric team. Individual records are kept on each patient thus allowing immediate access should the patient require further chronic medical intervention or treatment of an acute illness. Team recommendations are sent to the attending physician and they are reviewed. Coordination of the recommended services, or placement, are done by the team members. An essential component of the team process is the identification of gaps in services. A senior advisory board is part of our program.

Our program has not sought any Federal funding. It is our feeling that a majority of the money available must be directed toward actual services rather than administration of the projects. A small percent of the money should be given to supplement the directorship of such programs, however, most money should go to direct services.

I think that you will find that the demonstration projects are somewhat duplicating services. If you look at Monmouth County, I think that you will find assessment skills within our five hospitals and our public health agencies.

Thank you for the opportunity to briefly explain our program at Monmouth Medical Center. I would also like to briefly mention a project that our hospital has cooperatively undertaken with the Manchester Regional Health Care Corp. The geriatric system would include an 80-bed hospital, 120-bed nursing home, educational components, congregate housing units, and professional office space. The necessary number of beds (acute care) in the area is a major issue at this point.

Again, thank you. Please feel free to contact me if any further information is necessary.